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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

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Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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VOLUME 60/NUMBER 1



## President's Page



### What Lies Ahead?

As we begin this new year, one can't help but wonder what lies ahead in the private practice of medicine for 1973. This past year did produce some changes in our way of practicing medicine, but many thought that some type of national health program would be the law of the land by this time. I hope that this year will not be the year for any such sweeping program, and I optimistically do not believe that it will.

The most important piece of legislation passed by the 92nd Congress in 1972 will begin to be felt by all of us this year, and will undoubtedly extend into the future for many years to come. This was the passage of the all-encompassing HRI, which covered many facets of health care and medical practice. This very massive bill, more than a thousand pages long, will take many months to unravel, and I am sure that many hidden problems will come to light. At this time, it appears that the Bennett Amendment or PSRO (Professional Standards Review Organization), will be the most important part of this bill, as far as you and I are concerned. After modification in the Senate and House Conference Committee, this legislation was much more compatible with our own aims in providing quality health care in the private sector of medicine.

The original Bennett Amendment provided for Review Committees made up of a majority of consumers, but the final version allows physicians to render peer review over other physicians. These review organizations will be responsible for seeing that quality medical care is provided in the appropriate setting. At this time, cost is not supposed to be a factor, but I am sure this will very soon be a part of the program. The Secretary of HEW has the responsibility of certifying groups of physicians as the official PSRO for a particular area. At the moment, these areas have not been defined. The law also points out that if review organizations satisfactory to both the Secretary and the area physician cannot be set up, then the Secretary has the prerogative of setting up his own review organization, not necessarily composed of physicians.

Many of the details have not at this moment been worked out, and the actual running of the program will be spelled out in the regulations which are currently being put together. Although your AMA vigorously opposed PSRO, now that it is the law I am glad to report that the AMA, through its Board of Trustees and House Delegates, has grabbed the reins and is lending the leadership that will be necessary to make this a workable program.

Although we did not want or ask for this bit of legislation, I do sincerely hope that we can control it in a way to make quality medical care available without a sweeping national health program.

*William J. Dean, M.D.*

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# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions

# A New Dosage Form:

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addendum

### INDICATION | DOSAGE SCHEDULE

MINTEZOL<sup>®</sup> (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



"...a more satisfactory treatment..."<sup>1</sup>



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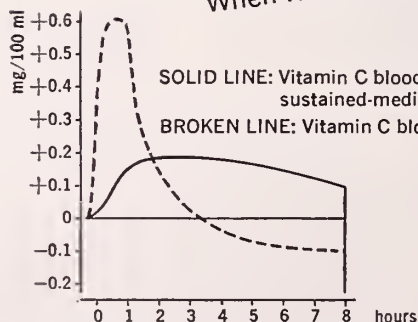
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<sup>\*</sup>Adaptation

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<sup>1</sup> Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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# Encounter under the Scanning Electron Microscope

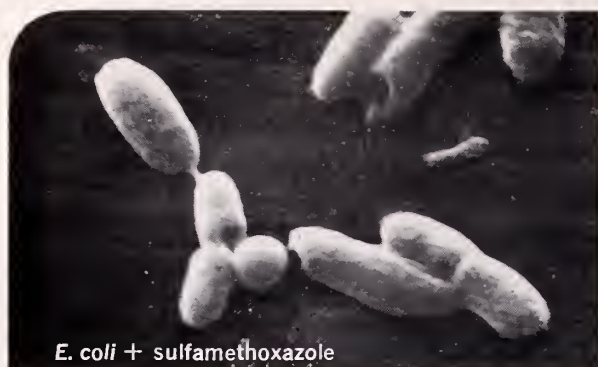


## SEM reveals changes in *E. coli* exposed to antibacterial agents

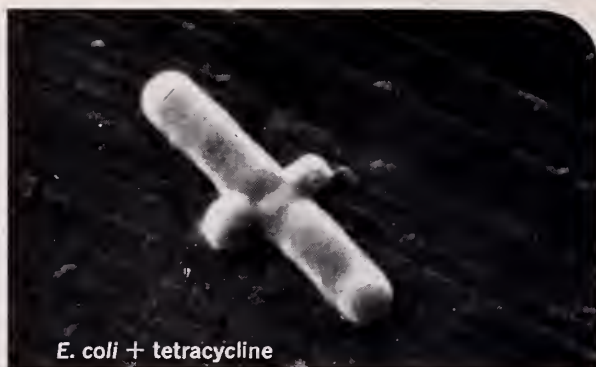
The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in

detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.





*E. coli* + sulfamethoxazole



*E. coli* + tetracycline



*E. coli* + cephalothin



*E. coli* + ampicillin

## Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,<sup>1-3</sup> strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of

its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

It should be noted that no clinical conclusions can be drawn from this study, as it is not always possible to extrapolate *in vitro* data to humans.

**References:** 1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971. 2. Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother.*, 1:164, 1972. 3. Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been estab-

lished. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CE and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose 6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** Blood dyscrasias (agranulocytosis)

# Encounter in Clinical Practice

## Control of primary bacterial offenders

Antibacterial Gantanol® (sulfamethoxazole) controls susceptible strains of *E. coli* and other gram-negative and gram-positive organisms

often implicated in acute nonobstructed pyelonephritis and cystitis.

## Prompt antibacterial blood and urine levels

In from 2 to 3 hours after the initial 2-Gm adult dose, antibacterial levels are present in

both the blood and urine.

## B.I.D./T.I.D. dosage for around-the-clock coverage

Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8 h. dosage regimen. Either schedule provides coverage during the waking

and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

## Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often re-

spond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents including sulfonamides, especially in chronic or recurrent u.t.i.

## Your Option: Tablets or Suspension

Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide

therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

**In nonobstructed cystitis and pyelonephritis due to susceptible organisms**

**Gantanol<sup>®</sup>**  
**(sulfamethoxazole)**  
**Basic Therapy**

lastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); **ergic reactions** (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctivitis and scleral injection, photosensitization, arthralgia and allergic myocarditis); **gastrointestinal reactions** (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and colitis); **CNS reactions** (headache, peripheral neuritis, meningoencephalitis, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); **miscellaneous reactions** (drug fever, chills, fever, phenomenon). Due to certain chemical similarities with the goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thy-

roid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

**Usual adult dosage:** 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

**Usual child's dosage:** 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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### Objectives for Medical Education

DONN L. SMITH, M.D.

As a new year begins and we rapidly approach the mid-point of the decade of the 1970's, it is appropriate to consider the objectives set for medical education at our institution for this decade, and to assess progress towards the achievement of those objectives. Although basic objectives in medical education may be categorized, they are often restated in a variable terminology. Indeed, it is sometimes difficult to retain a clear view of the multiple objectives in medical education as more sophisticated statements are made and as sub-objectives and more specific and relatively narrow goals are set. The original long term objectives of the University of South Florida College of Medicine set in 1970 to be achieved by 1980 are as follows:

1. To create and maintain an academic environment in which medical education may be conducted in a quality manner, and in which the production of new knowledge and community service may co-exist in a balanced and distinguished frame of reference.
2. To integrate the College of Medicine into the mainstream of the community, and to provide leadership in the improvement of health care standards in the community.
3. To function within the framework of the total University as an integral and valued part of the University community of scholars and students.

It is clear that many of our immediate goals which should lead towards achievement of the long term objectives listed above, have been pretty well accomplished. We are developing integrity, intellectual capabilities capacity for work and the exercise of mature judgment in both the student body and within the faculty. These are the keystones of the creation and maintenance of an effective and desirable academic environment. In terms of achievement of community related and University-based objectives progress is not as visible. The reasons are many, but a significant factor is the current development of trends and pressures, both internal and external which tend to widen the distance between objectives and the points of recognizable progress. It is the weight

of these trends which tend on occasion to invoke disregard for and the consequent loss of clearly defined objectives. Pressures for a more rapid production of physicians, socioeconomic forces which will modify medical practice and the ever increasing difficulty in the acquisition of resources all tend to produce actions based on expediency and conformation to "current trends." The result can be then, an educational enterprise in which the academic process follows trends and oscillations of public and governmental opinion, rather than a leading role towards firm and clearly perceived objectives. It is in the last two of our three major objectives that major deviations in direction are most apt to occur. Unfortunately, failure to achieve an appropriate function in the community and University mainstreams will inevitably impede progress towards the full realization of the first objective, i.e., to create and maintain a fruitful and productive academic environment. The problem faced by medical educators is that if we move forward only in terms of current trends and popular political pressures, we run the very real risk of merely achieving an environment that is simply an extension of our current difficulties and will be unable to achieve meaningful solutions to what are admittedly complex and difficult problems. Only by maintaining a clear and undistorted view of long term objectives, and by insistent and courageous movement towards the realization of those objectives may we ultimately achieve academic and intellectual distinction. In fact, it may be that the future justification for the very existence of academic medicine as we know it, will depend to a great degree upon the setting and achieving of viable and worthwhile goals.

The administration and the faculty at our institution are fully committed to the achievement of our stated goals. Our progress to date has been visible and satisfactory and it is our hope that we will indeed achieve our goals in the context of a distinguished and responsible institution devoted to the primary objectives we believe to be appropriate for first rate medical education.

► Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.



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**Indication:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

“Probably” effective: For the treatment of vulvovaginal candidiasis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** None known. **Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued. **Dosage:** One applicatorful intravaginally twice daily for a period of 14 days. Course of therapy may be repeated if necessary.

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# FEEDBACK - from Pearl Street

## Histoplasmosis and Spelunkers —

Two young men from Pinellas County, ages 17 and 18, were recently diagnosed as having acute histoplasmosis. Approximately three weeks earlier they had explored some caves in the Hernando-Citrus County area. Such caves are a known repository for *Histoplasma capsulatum* and several Florida-acquired and cave-related episodes of histoplasmosis are in the files of the Division of Health. While starling roosts and pigeon and chicken flocks are primary sources of histoplasmosis in other states, cave-associated disease appears to be a unique feature of the Sunshine State. The organism has been recovered from caves extending over a large area of Florida, between Jackson and Baker counties on the Georgia border, and extending in a direct line south from Baker to Pasco County. *Histoplasma capsulatum* apparently flourishes in the guano enriched environment of a bat-infested cave. In the most recent survey of bats inhabiting Florida caves, the organism was isolated from 48% of the myotis bats examined. Most of the positive bats came from Alachua, Jackson, Marion and Citrus counties.

Histoplasmosis is acquired by inhalation of spores and the resultant acute respiratory infection resembles miliary tuberculosis, both clinically and radiologically. Physicians should be aware that spelunking groups, biology classes, and other persons inclined to visit or explore caves in the involved area are at risk. We would be well advised to question for a history of spelunking in the anamnesis of all patients with acute lower respiratory tract infection.

## Animal Rabies —

Provisional figures for the reported animal rabies (first three quarters of 1972) have just been released. The long established pattern of rabies in our wild and domestic animal life remains undisturbed. Thirty-six raccoons, 19 bats, 3 dogs, 3 cats, 1 bobcat, and a single skunk have been found positive for rabies. The risk of rabies in a bite from either a raccoon or a bat must be regarded as serious, since 15% of the raccoons and almost 10% of the bats examined this year have been positive. The risk of rabies

in other species, though not insignificant, can be viewed with considerably less alarm. It is interesting to note that of the 1,148 assorted chinchillas, gerbils, guinea pigs, hamsters, rats, squirrels and rabbits involved in human bites this year and submitted for examination, NONE have been positive. In fact, no rodent or rabbit rabies has ever been confirmed in Florida. Unless very, very unusual circumstances occur the risk from a rodent, squirrel or rabbit bite approaches zero. Animal rabies in Florida continues to be primarily a problem of wildlife, only infrequently involving household pets or domestic animals. The last human case of rabies in Florida was reported in 1948.

## Influenza —

One hundred and two sets of paired sera have been submitted to the Division of Health in recent weeks by private physicians for diagnosis in case of acute upper respiratory disease (influenza-like). Eight have been positive for adenovirus and mycoplasma infection; the rest are negative. No influenza A or B disease has yet been confirmed (12 Dec.) in Florida this flu season. An influenza A outbreak has been documented in the Baltimore-Washington area, and isolations of A<sub>2</sub> virus have now been made from several widespread areas of the U. S. (Tennessee, New York, Illinois and Washington states). However, the latter have come from sporadic cases occurring without an associated increase of upper respiratory disease in their respective communities.

## Eastern Equine Encephalitis —

Florida's first case of eastern equine encephalitis (EEE) for 1972 was recently confirmed in a 7-week-old female infant from Duval County. The child had a febrile illness with seizures and panencephalitis; a prolonged course with apparent residual brain damage ensued. Since 1957, 22 cases of EEE have been documented in Florida. The involved counties are in two broad bands; one traverses the north going from Walton to Duval and the other is a central belt from Pinellas and Sarasota east to Brevard. Five of the cases resulted in fatality, and significant neurologic deficit has been evident in the survivors.

## Medical News

### Book Dedicated to Dr. Lyght

The new (12th) edition of *The Merck Manual of Diagnosis and Therapy* has been dedicated to Charles E. Lyght, M.D. who was the editor-in-chief of the Manual from 1947 to 1966. Dr. Lyght is now serving as Associate Editor of *The Journal of the American Geriatrics Society* and is a member of the Editorial Board of *Current Therapeutic Research*. At present he is making his home in Oklawaha, Florida.

### MEDIPHONE in Operation

"MEDIPHONE," a service which offers physicians in all parts of the country telephone consultation with some 400 specialists, has been established by the American Society of Contemporary Medicine and Surgery.

Any physician, regardless of geographic location, can dial (312) 782-7888 and receive expert advice on a particular problem. There is a \$15 charge for a five-minute consultation.

Information about the program may be obtained by writing to John G. Bellows, M.D., Secretary, American Society of Contemporary Medicine and Surgery, 30 North Michigan Avenue, Chicago, Illinois 60602.

### Medical Meeting in Miami Beach

"Continuing Education for Excellence in Medicine and Surgery" will be the theme of the 1973 Annual Meeting of the American Society of Contemporary Medicine and Surgery, which will be held February 25 through March 3 at the Fontainebleau Hotel in Miami Beach.

Papers will be presented on cardiovascular diseases, proctology, gynecology, urology, otolaryngology, orthopedics, and gastroenterology, among others. Information may be obtained by contacting: Miss Virginia Kendall, 30 North Michigan Avenue, Room 1629, Chicago, Ill. 60602.

### FMA Honors Nurse Hart

Mrs. Delma Hart, R.N., of Tallahassee, has been honored by the Florida Medical Association for her service as nurse at the Legislative Clinic in the State Capitol at Tallahassee.

Mrs. Hart was presented with a plaque at the regular monthly meeting of the Leon-Wakulla-Jefferson County Medical Society on September 11.

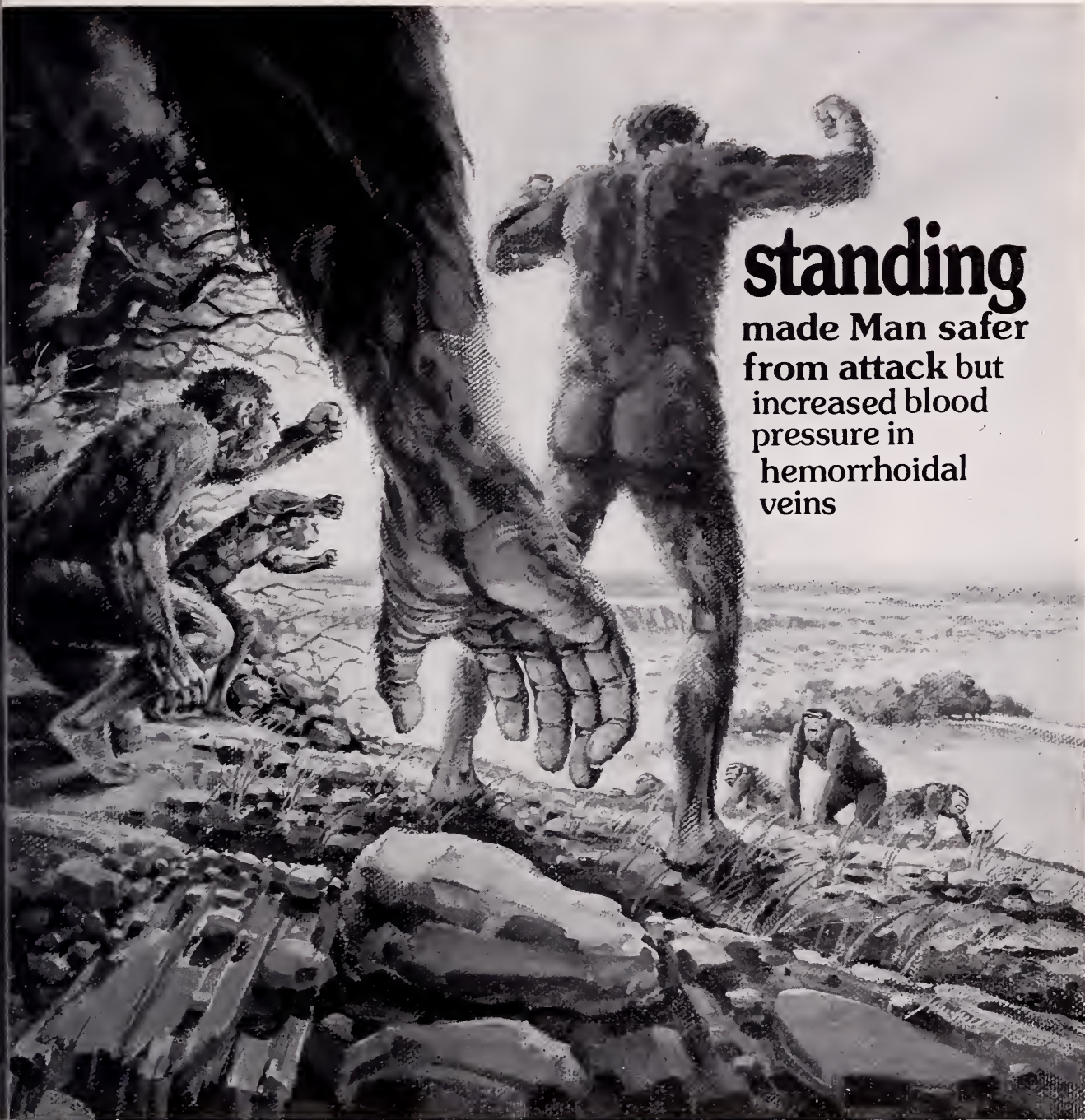
"I accepted the plaque in humble gratitude that so distinguished a body of men would recognize me in this manner," Mrs. Hart recently wrote FMA Secretary-Treasurer James W. Walker, M.D.

During the past few years, Mrs. Hart has been instrumental in the success of FMA's "Doctor of the Day" program, which makes a physician available to legislators and others every day the Florida Legislature is in session.



The presentation of the plaque to Mrs. Hart by Sen. Mallory E. Horne.





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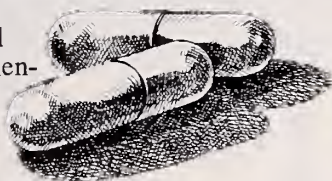




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**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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## The Treatment of Traumatic and Postsurgical Abnormalities of the Lacrimal Apparatus

JOHN W. SNOW, M.D. AND DONALD E. BAYLES, M.D.

**Abstract:** This paper discusses abnormalities of the lacrimal apparatus likely to be encountered by surgeons; describing the basic dynamic, functional anatomy of the lacrimal system and correlating with it various aspects of its surgical treatment. Illustrations and photographs are used liberally in an effort to make the paper more easily understood and readable. Two new techniques of the author are described, one of which has not been previously published.

Traumatic or surgical interruption of the lacrimal drainage system results in troublesome epiphora if not successfully reconstructed. Satisfactory treatment is predicated on an understanding of the anatomy and function of this highly specialized structure.

### Anatomy

The puncta are located in the medial aspect of the upper and lower lids and normally are in contact with the lacrimal lake. They are held open by a small cartilaginous ring so that they will not collapse when a negative pressure occurs within the system (see Function). In an adult the major portion of tear drainage occurs through the inferior punctum.

The canalicular portion of the lacrimal apparatus joins the puncta to the lacrimal sac. The anatomic relationships are shown in Figure 1. There are two membranous one-way valves in this system, one in the duct to prevent ascent of nasal material and one in the canaliculus to prevent retrograde tear flow.

### Function

The lacrimal system is operated by alternating positive and negative pressures.<sup>1</sup> This "pump"

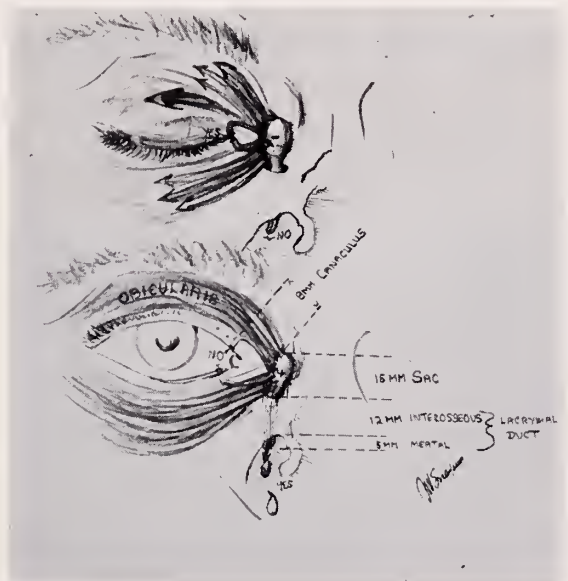


Fig. 1.—Illustrates anatomy and function of lacrimal apparatus.

action is carried out by the saccular portion of the system. Many of the orbicularis oculi muscle fibers attach to the lateral wall of the lacrimal sac. When these muscles contract, as in blinking, the sac is stretched thereby increasing its volume and producing a negative pressure within the system. Tears are then sucked into the sac via the puncta and canalicula while the valve in the lacrimal duct is closed. When the orbicularis oculi muscles relax, the previously stretched yellow elastic fibers within the sac wall begin their return to normal length and thereby produce a positive pressure within the sac. This ejects tears into the nose via the lacrimal duct as the one-way canalicular valve closes, thus completing the cycle (Fig. 1).

The very different anatomic and functional structure of the canalicular, saccular, and ductal portion of the lacrimal system dictates a modification of treatment dependent upon the area involved. Therefore, abnormalities within each area will be approached separately.

#### I. CANALICULAR

Canalicular injuries frequently occur at the time of a laceration through the medial aspect of the lower lid. The "dog bite" is a common cause of this injury. If the wound is clean and the general condition of the patient satisfactory, the canaliculus should be reapproximated around a 1.0 mm. polyethylene tube. This tube can be inserted through the punctum after a horizontal "snip" has been made to enlarge the opening and then threaded across the severed ends of the canculus and if possible into the nasal cavity. The anastomosis should be started posteriorly and include the conjunctiva since the tissue in this area is too thin to suture separately. The remaining portion of the anastomosis is then continued by carefully reapproximating the canalicular wall with 6-0 black silk suture. Two or three power magnification is helpful. (This anastomosis is no more difficult than reapproximating a severed digital nerve which is about the same diameter.) The remaining portion of the wound is then closed and the polyethylene tube cut off 1.5 cm. from the punctum and sutured to the lower lid. When the polyethylene tubing is removed at five to six weeks the anastomosis should be well healed and functioning satisfactorily. Occasionally the severance will occur at the juncture of the upper and lower canaliculus where they form a common duct just prior to entering the sac. Tangential severances in this area can be quite confusing if this

point is not kept in mind. If the anastomosis has been carefully done, it will usually function well. If a stricture should develop, intermittent dilatation may be necessary with a lacrimal probe.

#### II. SACCULAR

Saccular lacerations and perforations are usually undetected by either patient or surgeon and heal spontaneously.<sup>2</sup> The saccular portion (pump) of the system occasionally must be removed because of the juxtaposition of a tumor such as basal cell carcinoma. When the sac is removed some type of conduit for a gravity drainage system is necessary. The canaliculus cannot be used in a gravity drainage system since its internal diameter is too small. When the sac has been removed it is possible to anastomose the lacrimal duct to the conjunctiva by elevating the periosteum of the lacrimal canal circumferentially so that the lacrimal duct can be pulled out of the canal 1.5 cm., brought over to the medial aspect of the lower lid and anastomosed to the conjunctiva (Fig. 2). A 4.0 mm. polyethylene tube is left in place for two or three months and then removed, leaving the conduit to drain by gravity.

If this is not feasible, a window of nasal bone may be removed and a fistula formed between the lower lid and nose. This is maintained with a Jones<sup>3</sup> pyrex tube or simply a flanged 5.0 mm. polyethylene tube which is left in place permanently (Fig. 3). A large tube is used so that mucus and other debris may pass without causing an obstruction. Occasional removal and cleaning is necessary.

#### III. DUCTAL

The interosseous portion of the lacrimal duct will sometimes be severed in compound fracture lacerations of the nose. Because of its location within the lacrimal canal diagnosis is difficult and often missed.

When the severed duct is noted, a polyethylene tube should be threaded across to act as a stint and left in place two or three months. The chances of obstruction at the anastomosis are high and secondary reconstruction is often necessary.

When this occurs a dacryocystorhinostomy (forming an opening between the nasal mucosa and lacrimal sac) works well and is the treatment of choice. A large segment of nasal bone should be removed and a 6.0 mm. opening made between the abutting saccular and nasal mucosa. The posterior portion of the anastomosis is then secured





Fig. 2a.—Recurrent basal cell carcinoma of medial canthus.



Fig. 2b.—Wide local excision including medial aspect of lids, caruncle, canniculus and lacrimal sac. Lacrimal duct delivered out of bony canal and anastomosed to conjunctiva around polyethylene tubing. Forehead flap for closing defect.



Fig. 2c.—Postoperative, one year without epiphora.



Fig. 3a.—Recurrent basal cell carcinoma of nose fixed to nasal bones, right medial canthal area.



Fig. 3b.—Wide local excision of skin including upper lateral cartilages and nasal bones. Mucous membrane lining of nose preserved. Note polyethylene tubing which will be used for maintaining fistula between inner canthus and nasal cavity.



Fig. 3c.—Nose resurfaced with thick split-thickness graft. No epiphora at two years. Tube in place.

after which a 4.0 mm. polyethylene tube is passed into the nose. A smaller tube is threaded through the canaliculus and into the larger tube and there transfixed with a suture. The small tube is anchored to the lower lid and thus holds the larger tube in place. At two months they may both be removed through the nose. This operation works well and is used widely.

When the entire lacrimal system has been removed or damaged beyond repair, a satisfactory conduit can be made from nasal and septal mucosa (Figs. 4 and 5). If the nasal bone is present, the major portion should be removed.



Fig. 4.—Illustration of technique of total lacrimal reconstruction from a tube of nasal and septal mucosa.



Fig. 5a.—Recurrent basal cell carcinoma of medial canthal area fixed to bone.



Fig. 5b.—Wide local excision including medial aspect of upper and lower lids, caruncle, medial wall of orbit, nasal bone, etc. Nasal mucosa preserved.



Fig. 5c.—Inferiorly based flap of nasal mucoperiosteum and mucoperichondrium elevated high into cul-de-sac and then sutured around polyethylene tubing (Fig. 4).





Fig. 5d.—Postoperative, four months without epiphora. Wound closed with forehead flap.



Fig. 5e.—Dye study showing patency of conduit 18 months postoperative.

The nasal mucosa is then elevated from the remaining nasal bone along with the septal mucoperichondrium high into the cul-de-sac of the nose.<sup>4</sup> An incision is then made 1.5 cm. from the dorsum in the nasal and septal mucosa, thus forming a long, rectangular, inferiorly based flap. This flap is sutured around a 5.0 mm. polyethylene tube. It is swung over to the medial canthal region and anastomosed to the conjunctiva. This anastomosis should be at the lower part of the trough formed by the lower lid where tears pool. The polyethylene tube is left in place for six weeks and then removed. This conduit usually functions satisfactorily and no probing or cleaning is necessary.

### Summary

Various methods for reestablishing the continuity of the severed or surgically ablated lacrimal apparatus have been presented.

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► Dr. Snow, 2700 Riverside Avenue, Jacksonville 32205.

Obstacles challenge, but do not frighten brave men.

# Concomitant Herpetic Vulvovaginitis in Mother and Child Due to Herpesvirus Hominis Type I

ALLEN SHEVACH, M.D.

The potential of the Herpesvirus hominis, types I and II, to infect the developing fetus or newborn either by transplacental transmission or by virtue of delivery through an infected birth canal has precipitated their recognition as important pathogens for the female genital tract.<sup>1-3</sup> Though the majority of cases of herpetic vulvovaginitis are due to Herpesvirus hominis type II viruses, this is not an absolute rule.<sup>4-6</sup> We have recently seen a mother and daughter who presented simultaneously with herpetic vulvovaginitis, for which the causative organism was Herpesvirus hominis type I.

## Case Report

A 27-year-old divorced white female, para 1-0-0-1, presented to the emergency room on December 25, 1971, with her 5 year, 11-month old daughter because of a "vaginal infection."

The patient was well until December 19 when she experienced burning on urination which became progressively worse. In addition she experienced perineal pain and labial swelling. On December 21 she experienced chills, myalgias and a temperature of 103 F. She could not be examined because of her discomfort but was treated with penicillin and pain medication. Because of the failure to gain relief with the pain medication, she presented herself to the emergency room at the W. A. Shands Teaching Hospital on Christmas day. In addition her daughter complained of "mosquito bites on my bottom" on December 23 and burning on urination on December 24. Mother and daughter slept together on the same bed and their clothes were washed at the same time. They rarely bathed together. The mother had her last sexual exposure with a steady partner on December 13. He denied any clinical disease. Her last menstrual period was December 6 through December 11. She denied any previous history of similar attacks and ever having "cold sores."

On examination, the mother was afebrile. No herpetic lesions were present on the oral mucosa. The external genitalia contained both vesicular and ulcerated lesions with conglutination of the labia and were covered with a foul purulent discharge (Fig. 1). No distinct intra-vaginal or cervical lesions could be visualized. The cervix was reddened and covered with a similar discharge and was minimally tender on manipulation. Examination of the daughter revealed a few ulcerative and vesicular lesions and reddening of the vaginal mucosa (Fig. 2). The cervix could not be well visualized.

Laboratory data included a catheterized urinalysis of the mother and a clean catch on the daughter, which were within normal limits. Cultures of both maternal and daughter's lesions were positive Herpesvirus hominis. The cultures were forwarded to the laboratory of Dr. André Nahmias where both virus isolates were shown to be type I. Therapy was supportive and both patients were asymptomatic two weeks after their emergency room visit.

## Discussion

The case report reiterates two points: (1) Not all cases of herpetic vulvovaginitis are due to herpes type II. Based on Nahmias' study of children with and without sexual exposure, those without sexual exposure had type I virus and those with sexual exposure had type II virus. (2) Whenever a young child without evidence or history of sexual exposure presents with herpetic vulvovaginitis, the presumptive causative organism is type I. These points have therapeutic ramifications for Herpesvirus hominis type II does not respond to topical 5-iodoxuridine ointment whereas Herpesvirus hominis type I is sensitive to its topical application. The presence of systemic maternal illness and absence in the daughter strongly suggests in this case that the child's infection was acquired outside the home environment and that the child herself became the vector of infection to the mother.

Dr. Shevach is a resident in the Department of Obstetrics and Gynecology at the University of Florida College of Medicine, Gainesville.



Fig. 1.—Characteristic herpetic lesions involving the labia and perineal area in mother.



Fig. 2.—Herpetic vulvovaginitis of a 5-year-old child. Note the paucity of lesion characteristic of recurrent infection.

### Summary

A case of concomitant vulvovaginitis due to Herpesvirus hominis type I in mother and daughter is reported.

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### Acknowledgement

I wish to express my appreciation to Dr. Gilles R. G. Monif for his helpful guidance in preparing this report and to Dr. André J. Nahmias for identifying the virus isolates.

► Dr. Shevach, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville 32601.

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Time is  
 too slow for those who wait  
 too swift for those who fear  
 too long for those who grieve  
 too short for those who rejoice

But for those who love,  
 time is not.

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### *Grand Rounds*

## Agammaglobulinemia

DR. JOSEF FIALA: The patient is a 21-year-old student whose illness was diagnosed as agammaglobulinemia 13 years ago at Columbia University. Since that time he has been treated prophylactically with gammaglobulin injections monthly and oral sulfur daily. Except for frequent rhinorrhea, he has been well with few major infections. His mother recalls no infections, transfusions, or drugs during pregnancy and no complications at the time of delivery. At the age of several months meningococcal meningitis occurred and was effectively treated without difficulty. Fourteen years ago, when the patient was seven years old, he had pneumococcal pneumonia. Throughout the teen years and up to the present time, he has been bothered by acne and other skin infections. Since receiving injections of gammaglobulin, he has not had any serum sickness type reactions. He has had no arthritis, lymphadenopathy, or hepatitis. There is no family history of increased or abnormal infections.

Physical findings included pharyngeal redness and a discharge in the posterior pharynx. There was no hepatosplenomegaly or lymphadenopathy. Laboratory data included a normal CBC, negative latex fixation and normal SMA-12. Albumin was 4.9 gm/100 ml and C3 was 160 mg/100 ml. Immunoglobulin quantitation included an IgA of less than 10 mg/100 ml, IgM of less than 10 mg/100 ml and IgG of less than 100 mg/100 ml. The patient's blood group was A but his serum contained no anti-B agglutinins.

DR. NEIL ABRAMSON: "There was a man in the land of Uz whose name was Job and that man was wholehearted and upright and one that

feared God and shunned evil. Now it fell upon a day that the Sons of God came to present themselves before the Lord and Satan came also among them to present himself before the Lord . . . And Satan answered the Lord, 'Skin for skin, yea, all that a man hath will he give for his life. But put forth thy hand now and touch his bone and his flesh. Surely he will blaspheme thee to thy face.' And the Lord said unto Satan, 'Behold he is in thy hand, only spare his life.' So Satan went forth in the presence of the Lord and smote Job with sores and boils from the soles of his feet even unto his crown."<sup>1</sup>

This passage from the Bible represents the first description of increased susceptibility to infections, albeit an acquired disorder rather than the congenital variety described by today's patient.

The next literature that identified this altered immune state appeared in 1952. Colonel Ogden Bruton of the Walter Reed Army Hospital described the first documented case of agammaglobulinemia in a young boy who frequented the hospital with infections.<sup>2</sup> "He responded promptly only to come back again in two or three weeks. After the third and fourth times, we decided that there really must be something wrong with this boy so we kept him in the hospital for awhile trying to establish a focus for infection. We ran him through the mill. We did lung punctures, myelograms, every system was taken up systematically and we could find nothing abnormal with this boy . . ." Infections recurred approximately 19 times over the next four years and in nine instances pneumococcus grew from his blood stream. "We first attempted to control this with prophylactic sulfur and he broke through this and had repeated sepsis. This suggested that he possibly could not build antibodies for pneumococcus and very often we couldn't find any pneumococcal antibodies in his serum. He was given

Dr. Fiala is a second year resident in the Department of Medicine, Jacksonville Hospitals Education Program.

Dr. Abramson is Associate Professor of Medicine, University of Florida College of Medicine-Jacksonville Hospitals Education Program, and Chief, Hematology Division, Department of Medicine, Jacksonville Hospitals Education Program.

Presented at Baptist Memorial Hospital, Jacksonville, July 1972.



multiple doses of tetanus and diphtheria toxoid, yet he continued to have a positive Shick test." In retrospect, these observations were the first laboratory clues to his abnormalities. "Needless to say, in a place like this there are many distinguished people that come through the Walter Reed Hospital and this boy was always a patient that could be seen. Every time someone came through they suggested another laboratory test and usually the tests were normal. We were there with this boy one day when someone suggested that since he had permanently severe infections that he almost certainly should have a high gammaglobulin and a check of his gammaglobulin was suggested." Fortunately, a Tiselius moving boundary electrophoresis was being set up at Walter Reed and a specimen of serum was sent to the technician. A day later a report was transmitted that there was something wrong with the machine because all the proteins came out except for the gammaglobulins. Col. Bruton reported, "Things began to click then. Obviously he can't build antibodies because he has no gammaglobulin."

This is a magnificent example of an "experiment of nature" without which pure laboratory research would be nearly fruitless. Other experiments of nature have revealed important features of the host defense mechanisms. The DiGeorge syndrome is an example. Dr. DiGeorge, a pediatrician and endocrinologist interested in children with mucocutaneous candidiasis and tetany, discovered the important complications that occur in the absence of thymic tissue. Another syndrome, hereditary thymic dysplasia (Swiss-type agammaglobulinemia), is a disorder of both thymic and gammaglobulin abnormalities.

These congenital or inherited deficiencies permit the establishment of a general outline of the immune system. There are two well-established segments of this system: one influenced by the thymus gland and the second by the bone marrow in man. A stem cell may be directed by the thymus and the resultant lymphocyte (T lymphocyte) mediates cellular immunity (delayed hypersensitivity, graft rejection, blast transformation, etc.). Stem cells affected by the bone marrow (B lymphocytes), or in chickens the bursa of Fabricius, differentiate into secretory lymphocytes (plasma cells) which are responsible for the production of immunoglobulins or antibodies. Col. Bruton's case and our patient under discussion represent abnormalities of the B cells.

Let us discuss some of the clinical manifesta-

tions of agammaglobulinemia and stress the evaluation of a patient with increased susceptibility to infection.

The presence of agammaglobulinemia or hypogammaglobulinemia implies increased loss or decreased production of the proteins. The few circumstances in which immunoglobulin synthesis is normal but catabolism or loss is excessive include protein-losing enteropathy or the nephrotic syndrome when the glomerular basement membrane pore defect is large enough to permit the excretion of molecular weight proteins of 160,000 or more. Defects in synthesis include infiltration or replacement of the reticuloendothelial cells and bone marrow by abnormal plasma cells as in multiple myeloma, or by abnormal lymphoid cells in lymphoma, or by replacement of malignant cells as in metastatic carcinoma. In addition, there are acquired idiopathic forms and the congenital variety of hypogammaglobulinemia originally described by Bruton.

The congenital type of agammaglobulinemia is found in males, whereas the acquired idiopathic variety may occur in males or females. The congenital type may appear as early as a few months following delivery. The sporadic type usually occurs in young adults. Immunoglobulin deficiency regardless of cause results in repeated, frequent and severe infections. The bacterial organisms are pyogenic and include beta hemolytic streptococcus, pneumococcus, staphylococcus, *N. meningitidis*, *H. influenzae*, and *Klebsiella*. Patients are usually spared of fungal and viral infections. Bacteria cause septicemia, arthritis, skin infections, skin abscesses, pneumonias, upper respiratory infections, middle ear infections, and meningitis. It is uncommon for the infections to begin before the age of three to six months because of the protective effect of maternal antibody. A curious aspect of this disorder is an increased incidence of antigen-antibody phenomena despite the deficiency of immunoglobulins. Classical rheumatoid arthritis except for the positive latex fixation (rheumatoid factor) develops in these patients; also scleroderma, systemic vasculitis, Coombs' positive hemolytic anemia, thrombocytopenia, and leukopenia. Tissue sections may show vasculitis and a Shwartzman-type reaction. Whether this is due to the primary antigen-antibody phenomenon or to endotoxemia is unknown. Individuals with congenital agammaglobulinemia or acquired agammaglobulinemia have approximately 20 to 30 times more "connec-

tive tissue diseases" than the normal population. It is not uncommon for lymphoid, thymic or G. I. neoplasias to develop in some patients.

How does one evaluate the clinical picture of increased infection and then delineate the underlying immune abnormality? Normal white blood cell numbers and function, normal serum complement, and intact cellular immunity must be established first. In agammaglobulinemia, all these essential immune functions are normal. If one studies the patient's antibody levels and their ability to generate an antibody response, they are deficient or abnormal. Immunoglobulins can be visualized on electrophoresis. Figure 1 is an agarose electrophoresis of several serum samples.

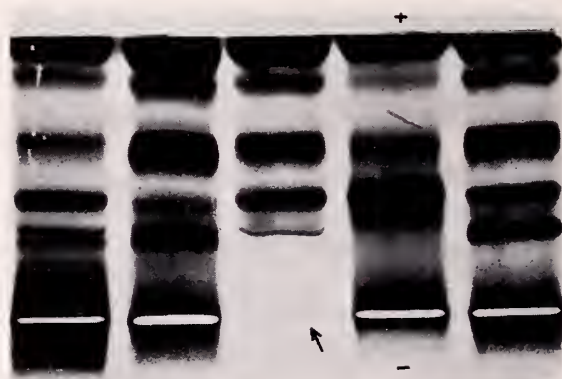


Figure 1

The immunoglobulins are slow moving proteins and occupy the most cathodal portion of the electrophoresis (lower portion). Note the virtual absence of immunoglobulins from the serum of a patient with congenital agammaglobulinemia. A similar protein pattern can be found in chronic lymphocytic leukemia, lymphosarcoma, and multiple myeloma when Bence Jones proteinuria occurs in the absence of a serum "M-component." Precise identification and quantitation of individual immunoglobulins by radial immunodiffusion establishes the diagnosis of immunoglobulin deficiency. Further studies include an evaluation of the patient's antibody response to a specific antigen. Serum samples may be measured for antitetanus

and antidiphtheria antibodies before and after a DPT booster. Little or no rise in antitetanus and antidiphtheria antibody levels are often observed. A biopsy of a node taken after the booster injection may be most helpful in establishing the diagnosis. In addition, anti-A or anti-B agglutinin levels are low or absent. The age at which one evaluates the individuals is important. Physiologic hypogammaglobulinemia, which normally occurs from the age of 2-6 months, may persist for over a year.

Treatment of agammaglobulinemia is precisely that described by Col. Bruton. Gammaglobulin injections at a dose of 20 cc a month is used initially but many patients require a much greater dose. Despite immunoglobulin deficiency, allergic reactions can occur. The most common transfusion reaction is directed against residual IgA in the gammaglobulin preparations or the IgA of plasma when whole plasma is administered rather than gammaglobulins alone. Ideal therapy consists of whole plasma or the IgG of plasma from the same donor, preferably one who has been typed and has similar Gm or Inv genes to the recipient. Gm typing is not done on a routine basis and consequently this more desirable type of therapy is only available at a few centers.

In summary, the patient today presents an example of congenital agammaglobulinemia. The infections have been pyogenic and have caused meningitis and pneumonia. He has not had any evidence of auto-immune disorders, such as rheumatoid arthritis, scleroderma, or Coombs' positive hemolytic anemia. The evaluation of such a patient includes the establishment of normal white cells, complement, and cellular immunity with isolated defect in the humoral system. Treatment includes life-long immunoglobulin replacement therapy.

#### References

1. Old Testament, Book of Job, Holy Scriptures According to Masoretic Text.
2. Immunologic Deficiency Diseases in Man, National Foundation March of Dimes, Birth Defects Original Articles Series, 4:2-3, 1968.

## BME Issues Warning

Florida physicians are reminded that only the Florida State Board of Medical Examiners can authorize an individual to call himself a "physician's assistant." The Board issued the reminder in wake of reports that an organization known as the American Association of Physician's Assistants is issuing certificates for a fee of \$20 indicating the individuals listed thereon are physician's assistants. BME Executive Director, George S. Palmer, M.D., said that unauthorized use of the term is a felony punishable by imprisonment up to 18 months and/or a fine up to \$5,000.





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## **Medical News**

### **Medical Reports on Driver Ability**

Medical reports evaluating an individual's ability to operate a motor vehicle should be disclosed only in a judicial proceeding, an FMA attorney believes.

Attorney Harry T. Gray of Jacksonville rendered an opinion on two related questions submitted by a member of the Medical Advisory Committee to the Florida Department of Highway Safety and Motor Vehicles.

In answer to one question, Mr. Gray maintained that the "Government in the Sunshine Law" does not require the Advisory Committee to release written medical opinions which it receives from physicians regarding the ability of patients to operate motor vehicles. By the same token, Mr. Gray wrote, the Committee should not release such information when requested by patients.

Such information should be released only when required in a judicial proceeding, he concluded.

### **ACCP Inducts Nine From Florida**

Nine Florida physicians were inducted as Fellows of the American College of Chest Physicians during the organization's 1972 Scientific Assembly at Denver, Colo.

The Floridians are: Julio C. Muniz, M.D., Tampa; Robert A. Turkel, M.D., Tampa; John C. Kruse, M.D., Jacksonville; Thomas E. Daly, M.D., West Palm Beach; Gordon F. Moor, M.D., Lakeland; Richard F. Tejera, M.D., Miami; Chang You Wu, M.D., North Miami Beach; Roberto Llamas, M.D., Miami Beach; and D. C. Catsaros, M.D., Tampa. All are members of the Florida Medical Association.

### **ACCP Course in Miami**

A postgraduate course entitled "Management of Acute Cardiorespiratory Failure" will be held at the University of Miami School of Medicine, February 26 through March 2, 1973.

Charles F. Tate Jr., M.D., is director for the course, one of eleven announced for the coming academic year by the American College of Chest Physicians.

Information may be obtained by contacting: Department of Continuing Education, American College of Chest Physicians 112 East Chestnut Street, Chicago, Illinois 60611.

### **Radiology Meeting in Miami Beach**

"Selected Topics in Genitourinary Roentgenology" is the title of a seminar that will be conducted at the Playboy Plaza Hotel, Miami Beach, March 26-31, 1973, under sponsorship of the Department of Radiology, University of Miami School of Medicine.

Fees include \$50.00 for residents and fellows; \$125.00 for others.

Physicians desiring additional information should contact Manuel Viamonte Jr., M.D., Department of Radiology, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

### **Central Florida Medical Meeting**

The Orange County Medical Society will conduct its 1973 Central Florida Medical Meeting at Disney World, near Orlando, May 31 through June 3.

The 1973 scientific program will cover cardiology, vascular surgery, arthritis and diagnostic problems.

Information may be obtained from: Harry L. Tucker, M.D., Chairman, Central Florida Medical Meeting, Orange County Medical Society, 800 North Mills Avenue, Orlando, Fla. 32803.

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**Pediatrics**  
Robert S. Eliot, M.D., Omaha, Nebraska  
**Internal Medicine**  
C. F. Gastineau, M.D., Rochester, Minn.  
**Internal Medicine**  
Joseph D. Godfrey, M.D., Buffalo, N. Y.  
**Orthopedic Surgery**  
James L. Grobe, M.D., Phoenix, Arizona  
**General Practice**  
Kenneth K. Keown, M.D., Columbia, Mo.  
**Anesthesiology**  
John M. Knox, M.D., Houston, Texas  
**Dermatology**  
Harold I. Lief, M.D., Philadelphia, Pa.  
**Psychiatry**

William M. Lukash, M.D., Bethesda, Md.  
**Gastroenterology**  
Richard F. Mattingly, M.D., Milwaukee, Wisc.  
**Gynecology**  
A. J. McAdams, M.D., Pittsburgh, Pa.  
**Colon and Rectal Surgery**  
Alden Miller, M.D., Los Angeles, Calif.  
**Otolaryngology**  
Robert D. Moreton, M.D., Houston, Texas  
**Radiology**  
Victor A. Politano, M.D., Miami, Fla.  
**Urology**  
Worthington G. Schenk, Jr., M.D., Buffalo, N. Y.  
**Surgery**  
W. A. J. Van Heuven, M.D., Albany, N. Y.  
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## Editorials

### Nothing Necessarily Has To Be The Way It Is

With the departing of the old year, let it take with it all remembrance of my unfair acts of greediness, the unintentional wrongs done others, hurt feelings caused by thoughtless remarks and the many times hesitating too late in saying something to make another feel better. No matter what has happened in the past, I, an individual, am responsible for what happens in the future. The problems of the world essentially are the problems of us, as individuals and if individuals can change, then the course of the world can change. We have come from somewhere and are going somewhere. The great architect of the universe never built a stairway that leads to nowhere.

The old year has gone and nothing one can do will bring it back. Yet, in the old year, actions of men demonstrated the dignity of labor, the sacredness of a promise, the value of friendship, the supreme worth of character as opposed to wealth, power or position and the rendering of useful service as the common duty of mankind.

In the New Year, the direction must be forward, to recognize the present ills of our society, to set about curing them, to re-adopt civility as part of good behavior, to re-establish high ideals and ethical morals.

May the New Year provide external challenge and internal motivation to prevent mental decline and physical deterioration. Nothing worthwhile comes from stroking the same comfortable ideas, uttering the same familiar platitudes or adopting the same unthinking postures of those around us. Welcoming diversity of opinion is an essential element of strength in the democratic way of life. While opposition for its own sake is neurotic and self-defeating, shaping the mind begins with ques-

tioning the status quo and with an unwillingness to accept customary truisms others erect as a defense against fresh thinking. The mind, no less than the body, needs activity, variety, change of pace and outlook, its own kind of isometric exercises, pushing against itself to gain shape and tone. This is the best and only insurance against the withering winds of old age.

Let us start the New Year by taking a long, hard look at ourselves, using past experiences as guide posts, judging objectively, trusting that we have grown wiser and not just older. As there will always be greater and lesser persons, one should not compare oneself against others, for to do so makes one vain or bitter. So, be yourself, enjoy your achievements, take kindly the counsel of the years, and keep interested in your own career. Fears are born of fatigue and loneliness but developing a gentle respect for oneself, and a belief in a purpose for one's existence on this globe will make one feel alive and useful as long as one lives.

In the New Year, remembering that integrity, self-reliance and self-respect are traits of character that must continually be practiced, help us to be honest, to be kind, to give a day's work for a day's pay and to make our families and friends happier for our presence. May association with colleagues, work in ghettos and the cries of the underprivileged tear the blinds of superstition, bigotry and prejudice from the windows of our souls. Finally, in the coming year, may we have a fresher awareness, a deeper compassion, a keener sense of joy in the small blessings that each day brings.

C.M.C.

# The Ills of Society

As a neurologist, I see women of varying age groups with headaches, backaches and dizziness attesting to numerous instances of psychosomatic disease directly related to abortions. Guilt, fear, and poorly worked out confusing emotional patterns have emerged from those who have had this experience. No one pretends to know the answer to this problem, but Dr. Bulfin, in the October JFMA, volume 59:40-42, 1972, sums up the feeling of many of his colleagues in the statement, "Abortion is an atrocity. Society must present a better solution than this."

I should like to comment on the sickness of our society when we expect:

Instant cure for colds or pneumonia with antibiotics

Instant relief of pain with analgesics

Instant sleep with narcoleptics

Instant relief of tension with a drink

Instant solution of undesirable or unhappy marriages with divorce.

And yes, instant relief of unwanted children with abortion. Doesn't it also strike close to home with instant solution to medical problems by consultations that don't always help; with medication that doesn't work the way it is said to work; or administrative problems whose solutions we palliate with "everything will be alright" only to realize some weeks later that it isn't.

The government has gone into the instant solution act with Medicare and Medicaid. Only the people and doctors know that the administrative bureaucrats and bungling clerical personnel

have caused a tremendous invasion of their privacy by solutions that have not really helped. My point, Friends, is that we live on earth, we are all humans with feelings and though we strive for heaven and complete euphoria, happiness and paradise, it does not exist here. Sooner or later, we will all have to return to this realization and work again within the realm of the natural law. We could even become very honest within ourselves. There are no quick, easy answers to the problems of life, be it indiscretion that leads to pregnancy or ill advised wars which are with us now and have been since time began. Sooner or later we must realize that if a human failure is our fault, we, being responsible, must suffer a bit, working it out as best we can through time and diligent effort, utilizing all our resources as human beings, not as animals who need gratification or live by instinct.

Perhaps if we turn with humility to our Creator and had love and prayer within ourselves the answers would not be all that elusive.

I read with great interest the article by Matthew J. Bulfin and I should like to commend the doctor for an excellent review of some of the literature, his overview of the problem and the statistics which are meaningful for those of us willing to accept such measures.

I feel that some of the above thoughts are pertinent to this particular problem.

JAMES B. PERRY, M.D.  
FORT LAUDERDALE

## "Medicaid" — L'Enfant Terrible

Born out of wedlock into a family of hate and suspicion, rejected by its natural father and despised by its foster parents this two year old continues to grow despite continuing parental abuse and a markedly inadequate diet. Phillip Hampton,\* who is most often credited with being the reluctant father of this state's Medicaid, says, moreover, that "the little bastard isn't doing too well," and suggests that it be separated from its mother—Family Welfare.

The special Medical and Dental Conference held Sept. 8th and 9th in Tampa left little doubt, however, that a late wedding with counseling and understanding can afford this infant not only legitimacy but the care and love that could give it an opportunity to *thrive*. It becomes the duty then of the Private Sector to join with state and federal medicine to make Medicaid respectable, meaning "belonging to one's own family or clan" and implies a group rather than a single individual as improperly understood by many today.

Dissatisfaction with the present system was apparent at the meeting. The public and their

elected representatives are dissatisfied with the ever rising costs of medical care and the apparent difficulties in obtaining it. The physicians are dissatisfied with inadequate payment and the ever increasing load of paper work required of them in order to receive such payment and the hospitals and nursing homes are dissatisfied with what they consider unrealistic financial considerations for their services.

The meaningful dialogue established at this meeting must continue. Certainly, it did not solve all of the above dissatisfactions but it indicated clearly that there is a sincere desire by both the doctor and the state agency to work together in building a more acceptable program and hopefully a really good one for the "whole family."

Mr. Ed Davis, the regional consultant for HEW, defined the federal government's part in this undertaking clearly when he said Washington is willing to supply the paints and the brushes but that it wanted the State of Florida to paint its own picture. At the present the State has formulated a rough outline (referred to frequently during the meeting as a bare-boned program). Now it would appear up to the private sector of medicine to fill in the details with the right medium that can best stand up under the ravages of time.

The studio door is open. Won't you come in?

Matthew E. Morrow Jr., M.D.  
Jacksonville

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*\*Footnote from Dr. Hampton: "I will admit to playing a part in designing the Florida Medicaid law which is entirely adequate for a good program. The illegitimacy I alleged in the statement quoted, refers to the current unsatisfactory program which does not follow the intent of the law, but is directed by rigid inadequate line item appropriations by the Florida legislation and is implemented as part of the welfare program and not as part of the health program for this State. It will be impossible for the 'private medical sector' to cooperate with the 'public sector' to improve Medicaid as long as it is a welfare program with inadequate rigid State appropriations."*

## Don't Overlook This Tax Deduction

The IRS views the cost of driving from your home to your office as a nondeductible commuting expense; however, driving to the hospital is another matter. Whether you leave from your office for routine hospital rounds, or are summoned from your home on emergency call, the driving costs are legitimate business expenses and can be deducted.



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# What is Your Community's M. S. S. Q.?

A Report of Surveys in Pensacola to Determine the  
"MEDICAL SERVICES SATISFACTION QUOTIENT"

PHILIP B. PHILLIPS, M.D.

**Abstract:** Physicians can best determine the medical needs of their own area. Here is a combined report of three surveys made in Escambia County to determine the need for physicians and the particular types, the availability of physicians to new patients, and finally, the attitude of patients to the available medical and hospital care, their satisfactions and their complaints. The author proposes a novel measuring device, the M.S.S.Q., or "Medical Services Satisfaction Quotient," by which, once the required surveys have been completed, the rating for a community may be calculated. On a 4.0 scale Pensacola and Escambia County rate a 3.0, better than "passing" but there is room for improvement. This challenge goes out to other counties—What's your M.S.S.Q.?

The thoughtful physician probably knows more about the medical needs of his community than anyone else. However, he has been castigated, denigrated, and has suffered contumely from the social planners who, in their indignation at the alleged neglect of the ghettos and the isolated rural areas, failed to appreciate the forward progress made in medical care in the past few decades.

### Responsibility for Evaluation

Because of firsthand knowledge, it is then the proper responsibility of the medical profession to document carefully the strong and the weak points of medical care in their own communities. If physicians will outline realistically what the true needs are, then intelligent planners, legislators, and public officials may work toward accomplishing the needed and verified goals to assure improved care for the public.

The Escambia County Medical Society is both progressive and aggressive in seeking to meet the local needs. This awareness of responsibility has been churning at a subliminal level in the minds of the officers and members of the Society for several years and has grown more urgent since our friend and fellow citizen, Governor Reubin Askew, assumed the governorship of Florida. His own sensitivity to the needs of the unfortunate, his honest intentions to improve the availability of medical care and his challenge to his good friends in the Florida Medical Association cannot go unheeded.

Planning in the Executive Committee of the Medical Society led to a multifactored approach. First we should determine how we were equipped in trained personnel. Did we have too many doctors, too few, or the wrong kinds? What did the physicians themselves think we needed for adequate care of the patient load? A Physicians

Dr. Phillips, a practicing psychiatrist in Pensacola, is Vice Chairman of the FMA Council on Legislation and Public Agencies and a Past President of the Escambia County Medical Society.

Placement Committee headed by Dr. Dale E. York, a prominent senior surgeon of the community, developed, distributed, collated and tabulated a questionnaire covering the information sought. The questionnaire was distributed to all members of the Society.

The Executive Committee was well aware of the excellent hospital facilities available in Pensacola. They, too, were justifiably proud of the Pensacola Educational Program (P. E. P.) which the medical society sponsored with the full support of all three general hospitals for the graduate medical education of interns and residents and its later expansion to include training for medical students by way of clinical clerkship. The full-time "professors" and the many voluntary physicians giving time to this program assured the community of a continuing medical education program for all and made possible the existence of many, many clinics for indigent patients, clinics which would not have existed without this program.

### Physician Availability Study

The Northwest Florida Comprehensive Health Planning Council, under the chairmanship of Dr. Noojin Walker, requested a physician availability study be done in Escambia County. This was for the purpose of determining how accessible physicians' services were to residents of the Escambia County area. It was approached from the standpoint of a new resident coming into the community trying to establish some medical relationship or medical record with a local physician. All doctors listed in the telephone book were called and three basic questions were asked of each doctor's office: (1) I am new in town. How soon can I get an appointment to establish a medical record with the doctor? (2) It is not an emergency but I do need to see a doctor as soon as possible. (3) What should I do if it is a real emergency? The results of this study indicate the efforts that physicians are making to see patients promptly. More than a third of the doctors contacted could see the patient that same day and almost half of them would *try* to see the patient that day. This survey shows the shortage of specialists in internal medicine and pediatricians in the Pensacola area.

But, what did the consumers think of the medical services available to them? Had they suffered any neglect, failed to get needed care, lost relatives because of medical intransigence, or

unconquerable economic hurdles? Were they participants in private medical insurance programs, or were they covered by their employer, or the Federal Government, or Medicare, Medicaid, Champus, or Family Services? A questionnaire was developed and evaluated by several knowledgeable people for suitability, clarity, comprehensibility, and appropriateness. Sampling of the population was established by choosing people to represent the various categories into which our community could be divided. Such general groupings included the well-to-do, the white collar employed, blue collar employed, and unemployed, white and black, single and married, old and young, with and without children, active military and retirees, industrial families, and private business families. The numbers of representatives in the sample were estimated by the opinion of the pollsters as to the per cent of the population the particular types represented. Copies of the "Health Care Questionnaire" were distributed to the selected population along with an explanatory letter and a stamped self-addressed envelope. After two weeks an 82 per cent response had been obtained based on the original request and one telephone call to each addressee.

### Questionnaire Sections

The questionnaire was divided into sections based on (1) opinions of the respondent, (2) his experiences, and (3) his relationships. In the section on opinions it was pleasantly surprising to the polltakers to find that 83 per cent of the respondents felt they had a dependable family doctor on whom they might call and 87 per cent felt that they were perfectly capable of selecting a specialist for their own medical needs. It was equally gratifying to find that 100 per cent of the people felt Pensacola had excellent hospitals and well qualified medical specialists. It was not surprising to find that 79 per cent of the respondents felt more physicians in general practice were needed in our community and even a third of the people felt more specialists were needed. None of the people in the representative cross section of the community had ever made a formal complaint to the county medical society because of what he or she thought was unsatisfactory medical care. We felt this was an important finding because of the increasing tendency of people to speak up about their displeasures.

One of the critical responsibilities of a medical society is to be certain that the public does not



suffer medical neglect because of inability to see a physician. For this reason, the questionnaire, Section on Experiences, was particularly of interest. Here, 91 per cent of the respondents feel they have never suffered medical neglect because of their inability to see a physician, but 9 per cent feel that they have. Twenty five per cent of the respondents have been unable to get appointments with their doctors, but 75 per cent have not had this problem. Though physicians are sometimes accused of being mercenary, it was refreshing to find in answer to another question that none of the respondents had ever been refused further appointments by a physician because the patient was seriously behind in his payments. It was learned that 29 per cent of the respondents had been in the hospital for treatment in the past 12 months and 79 per cent had been under treatment as an office patient during the past 12 months. Only 19 per cent of the respondents ever go to the emergency room of a local hospital for care when they cannot see the doctor of their choice.

### Third Party Coverage

Eighty-seven per cent of the respondents have health insurance, but in only 32 per cent of the cases does this insurance cover outpatient care in the doctor's office. Thirteen per cent of the poll-replying persons are covered by Medicare, 9 per cent by Medicaid, 17 per cent by Champus, and 61 per cent by privately held insurance or their own personal funds.

All of those replying indicated that they take the medicines as prescribed by their doctor and try to follow his advice carefully. A very important point from the sociological standpoint is whether or not a citizen's health suffers because he does not get the care he needs. It was thus particularly interesting that a question which states, "Many people want more and more medical care, sometimes more than they actually need. Do you feel your health has suffered because you didn't get the care you needed?" was responded to 100 per cent in the negative. No one suffered because of unavailability of medical care. It was also somewhat revealing to physicians to find that only 36 per cent of the people realize that in spite of all the government programs, many patients were still cared for without charges by practicing physicians. A question regarding changing of physicians showed that 22 per cent of the respondents have changed doctors in the past three years.

### Comments of Patients

The personal pleasures or displeasures of the consumers is more specifically delineated in the comments they made. Seventy-four per cent either commented favorably or had no criticism, and 26 per cent had suggestions to make for improvement in medical services. One wrote, "Doctors are too busy. They need to make more use of paramedical personnel." Another said, "Insurance companies should provide for outpatient care."

One person more concerned than others wrote in more detail: "I have been refused appointments on two occasions by one of your physicians. The first time was about the first part of 1972 because an appointment had not been kept in 1967. On April 18, 1972, I was refused an appointment because he didn't feel any continuing responsibility for me since he had not seen me since 1967 and he suggested I contact another doctor. I was off work for three weeks being treated for muscle spasms in chest. The ailment persisted and I was admitted to Baptist Hospital and tests and x-rays revealed a hiatus hernia."

Other comments were: "I only go to specialists for needs in their field." "We need more dentists and eye doctors." "I have had no medical neglect because I couldn't see a doctor, but I have friends who had to wait in the emergency room of hospitals much too long before being treated." "I have had to change to a different gynecologist to get regular check-up appointments." "I changed from one gynecologist to another to get appointments sooner, also from one eye doctor to another for the same reason." "The care is excellent once an appointment is obtained or waited for." "I needed medical attention for an intestinal upset and flu and my internist would not see me at all. Call me in a month, he said, and I'll see you. When he took me on as a patient, he said he would take me on in time of illness. I have changed to a G.P. that I can depend on. I have a psychiatrist I can count on and a urologist."

"The nursing care at — Hospital is not always up to par. On the psychiatric unit it is excellent, in urology it is terrible, but in other departments I have received good to excellent care."

"I was given an appointment with a cardiologist because of my blood pressure. After filling out forms for them stating I had had shock treatments, the doctor took me into his office and told me he could not accept me as a patient because of this. Then he charged me for an office visit. I left

the office crying. That's poor management."

"Why do G.P.'s charge such high prices? Some G.P.'s charge \$10.00 for a two or three minute visit and another \$5.00 for a urinalysis. A qualified urologist will check the urine, give a treatment and talk to you as long as necessary, all for \$8.00. This G.P. will charge you over \$24.00 if you have anything wrong and he does anything for you. I have seen doctors for years and not had to pay such prices. The patient doesn't care about the new devices, he only wants help from his doctor." "People have their own G.P. to get treatment when it is needed. If you get sick and need your doctor, this G.P. still sends you to the emergency room, even though he is in his office working. The emergency room charges more than most doctors do in their offices."

"It seems you always have to wait at least two or three weeks before an appointment. Why is it so hard to get appointments and when you

do get them, you have to wait for one or two hours before being seen?" "Visits to doctors always seem so high."

"About bills from the Medical Center Clinic, why can't small bills and bills from doctors be on one bill for Champus?" "You have to wait too long for appointments sometimes." "I change doctors only for special problems." "I am very pleased with the medical care I have received."

"I have been fortunate enough to have been in nearly perfect health all my life." "The medical care I have received in Pensacola has always been of the highest quality. It is, however, difficult for a new resident to locate a family physician. Doctors seem reluctant to accept a new patient on an emergency basis or without a referral."

"Many people have to wait far too long for appointments, so I am sure that more doctors are needed." "Many people do not know to go to an

### The "M.S.S.Q."

The postulated Medical Services Satisfaction Quotient (MSSQ) is a rough mathematical expression of a combination of the elicited data.

The equation proposed for the MSSQ is as follows:  
 $(G + S + H B + E R) \times A \times I - C. D. = S Q$

SYMBOL	MEANING	DEFINITION	PENSACOLA SCORE
G	Generalists	Percentage of population having a family doctor.	.8
S	Specialists	Availability adequate if not short in over 3 specialties.	1.0
H B	Hospital Beds	No bed shortage and no delay in hospital admission.	1.0
E. R.	Emergency Room	Staffed 24 hours a day and no emergencies turned away.	1.0
A	Accessibility	Appointments available in a reasonable time at reasonable rates (33 per cent can be seen on first day, 50 per cent in a week, 75 per cent in a month).	.9
I	Insurance	Percentage with in or outpatient coverage for necessary care.	.9
C	Complaints	Number of formal complaints to Medical Society per 10,000 people/year. (One malpractice suit equals 10 complaints	0
C. D.	Changing doctors	Percentage of persons changing doctors per year.	8%

Thus in Pensacola, based on this study, the MSSQ would look like this:

$$\frac{(.8 + 1.0 + 1.0 + 1.0) \times .9 \times .9 - .08}{0} = S Q$$

$$\frac{3.8 \times .9 \times .9}{0} = \frac{3.08}{0} - .08 = 3.00 \text{ (S Q) (Pensacola)}$$

On this scale anything over 2.5 would be rated as satisfactory, and

$$\frac{(1 + 1 + 1 + 1) \times 1. \times 1. - 0}{0} = 4.0 \text{ or a perfect score.}$$

emergency room when they can't see their doctor. A friend of mine is seriously ill in the hospital now. He asked to see a doctor and was given an appointment three months off. This is wrong."

#### Escambia Service Area

Escambia County has a population of approximately 220,000 people and serves a medical community of more than 350,000 people. There are approximately 170 physicians of whom 150 practice a specialty. Three general hospitals represent approximately 900 beds. The members of the Escambia County Medical Society are appreciative of the help given them by the respondents to this questionnaire developed by the Executive Committee. It is reassuring for us as physicians to hear that no one's health has suffered because he was unable to get the care needed and that only 9 per cent feel they have had some neglect because of their difficulties in seeing a doctor of their choice. It is gratifying to know that financial factors or delinquent accounts have not caused a refusal by doctors to see patients.

Obviously more health insurance should cover outpatient care in the physician's office. More general physicians or family physicians are needed in the Pensacola area. Surgeons and obstetrician-gynecologists perhaps should seek better opportunities elsewhere.

More pediatricians are needed and the P.E.P. program of residency training, in affiliation with the University of Florida College of Medicine, may provide the needed children's specialists. Neurosurgeons, orthopedists and psychiatrists could find enough work to start a practice. It seems agreed by the medical community that a

few more physicians of the proper specialties and a number of family physicians will be welcome additions. Some 23 new members of the Society in the past two years is indicative of the fact this need is known.

As physicians, we do not want to emphasize use of the hospital emergency rooms for anything except real emergencies. The point has been made by a patient that it often costs more to go to the emergency room than to see your own doctor in his office.

Younger physicians may be setting their fees too high. General practitioners charging appreciably more than specialists is also a new and unusual complaint. The changing of doctors by patients seems more a reflection of the patient's desire for greater accessibility than for any other cause.

#### Conclusion

The information presented here from these three studies is considered valid, interesting to physicians and reflecting a realistic picture of the medical services available in Pensacola and Escambia County. The M.S.S.Q. is a novel approach to evaluation of services available to the community and permits a rough rating or grade for a particular political or medically served population. As such it should have informational value to health planning councils, legislators, and other medical societies who are posed a friendly challenge to study these and similar aspects of medical care in their own communities.

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## What Price the Fee-For-Service Principle?

French physicians negotiating with the nation health insurance plan did save fee-for-service medicine—but the price was a single, rapid fee schedule for the whole country. Participating M.D.s lose tax deductions and retirement benefits if expelled for fee violations, and patients of an M.D. outside the plan collect only about a quarter as much as those whose doctor is in it. A French connection to U.S. prospects?



# Working Within the British National Health Scheme

EVERETT SHOCKET, M.D.

**Abstract:** During August, 1971, the author served as a Senior Surgical Registrar within the British National Health Service at a peripheral London hospital. He rotated night call, did surgery, made ward rounds, and held outpatient sessions; in essence, merged himself entirely into the British Health Scheme, and found the British National Health Scheme providing medical care that is good and uniform across the country. Physicians are well-trained, and the nurses spectacularly dedicated. Considering the British economy, the unique homogeneity of culture, the emphasis on humanism, and values that permit endurance of minor inconveniences, the present National Health Scheme seems practical, and approaches the average Britisher's expectation for health care. Precisely for these same reasons he concludes that the British system could not be successfully transplanted to the U.S.A. Our American tradition of individualism, our current suspicion of authority, our plunge towards dehumanization, and our current internal disharmonies would jeopardize a British-type National Health Scheme within the U.S.A.

During August, 1971, I served as a Senior Surgical Registrar within the British National Health Service at a peripheral London hospital. I was paid the customary 62 pounds (about \$90) per week; I rotated night call, did surgery, made ward rounds, held outpatient sessions; in essence, merging myself entirely into the British Health Scheme.

The British National Health Scheme began shortly after World War II. During those six war years, citizens in bombarded cities and soldiers on battlefields received medical care that was essentially socialized. Thus, the transition to a fully socialized plan was smooth. The British National Health Scheme, now 23 years old, is viable and functions better than most American physicians are led to believe.

The development of a single health care system was facilitated by the British national character itself. Their 50 million population has a proud historical-cultural heritage serving to bind them into a national family with a "mother" Queen. There is a single religion, common philosophy of life, tradition of fair play and a pride in preserving one's aplomb. There is great respect for authority. Graft is relatively unknown.<sup>1</sup> Taxes are deducted from paychecks. At no time does the British citizen calculate the deductions for himself. He accepts the government calculation and assumes it to be correct, just as he accepts the British National Health Scheme, its doctors, nurses and their competency. Perhaps the key word in the British National Health Scheme is "British." National pride is the motivation to make the system effective, expressly because it is British.

Thus, the average Britisher's expectation as to the health care he should receive is rather uniform and, indeed, is being reasonably fulfilled by the N.H.S. This expectation is less demanding and certainly more homogeneous than in America. The critical gap, between our American public's health care expectation (high quality, less cost, and "now") and our actual U.S. health care delivery, is not found in Britain. Though the British N.H.S. seems to fulfill the needs of most, some 3 million Britishers are dissatisfied enough to seek private insurance.

Why then, do many British physicians migrate to the United States? Although some leave shortly after medical training for economic opportunities elsewhere, the majority leave after receiving their postgraduate training, and do so reluctantly, having failed to secure a Consultantship within the N.H.S. Consultantships are at a premium, each hospital having a fixed number. Within the entire United Kingdom there are only about 900 Consulting Surgeons. The average Consultant works in more than one hospital, devoting nine half-day sessions to the N.H.S., retaining for private practice the remaining two sessions (a five and a half day week involves 11 sessions).

Assisted by Barbara Shocket, M. Ed.  
Financed by Herbert Jerome Fund.

Competition for a Consultantship appointment is intense. There are many qualified Senior Registrars (the equivalent of our most senior resident) waiting. Of some 9,431 Consultants throughout the U.K. in 1969, only 1,342 were under the age of 40! During those waiting years the Senior Registrar, eminently well trained, shoulders a full load of patient-care responsibilities which would otherwise be carried by a Consultant. Inasmuch as the Registrar earns about 3,000 pounds a year, while the Consultant earns double that, the government has been getting a bargain, namely, work done by men professionally qualified to be Consultants, but forced by circumstances to remain Senior Registrars. Typically, when a Registrar reaches age 40 his frustration climaxes and he may choose to migrate. This choice then, should not be viewed as a reflection of his dissatisfaction with the concept of the British N.H.S. *per se*.

An additional facet of the Consultantship sweepstakes is that the opportunity for appointment as Consultant is greater if one's registrar years have been spent in a big city teaching institution. Thus, capable British physicians leave the more provincial (outside the big city) hospitals which must then rely on non-Britishers to fill their Registrar posts.

### Surgical Care

My experience illustrates the kind of responsibility a Senior Registrar may shoulder. I, as the locum Senior Registrar, assumed responsibilities in the outpatient sessions as well as in the operating room. Working in the operating room (i.e., theatre, a place where operations are performed) was a delight!

A complete session of surgery may be planned in advance. Patients already in the hospital needing surgery get priority; the waiting list is then culled to fill out a session. The surgeon sets his own pace, ever conscious of the need to reduce the waiting list. The operative permit is permissive, clarifying that no particular surgeon has been promised (Fig. 1). Surgery begins at the reasonable hour of nine a.m. There is no colleague waiting restlessly to follow, nor must you, in turn, wait for someone else to finish. One's time is too clearly demarcated for there to be any distracting conflict.

The hospital had a single operating room, with one adjoining anteroom, where the patient was anesthetized prior to his being brought to the theatre itself. Thus, as the first patient's abdomen

### Consent to Treatment 'A'

Hospital \_\_\_\_\_

FORM I. CONSENT BY PATIENT \_\_\_\_\_ of \_\_\_\_\_

I hereby consent to undergo the operation of \_\_\_\_\_  
the nature and effect of which have been explained to me by  
Dr/Mr \_\_\_\_\_

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a general, local or other anesthetic for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular surgeon.

Date \_\_\_\_\_ (Signed) \_\_\_\_\_ (Patient)

I confirm that I have explained to the patient the nature and effect of the operation.

Date \_\_\_\_\_ (Signed) \_\_\_\_\_ (Physician/Surgeon)

Fig. 1.—Operative permit includes "no assurance has been given to me that the operation will be performed by any particular surgeon."

was closed, the succeeding patient was anesthetized, without delay. Under the anesthesiologist's supervision the same anteroom also served as a postoperative recovery room. The anteroom is, indeed, a convenience for the physicians but exists primarily for the patient's comfort. Such humanistic concern appeared to pervade British medicine. The patient never sees the stark instrumentality of an operating room, as he is asleep before entering it. At no time is the sedated preoperative patient asked to crawl and huff his way across onto a cold hard O.R. table. Rather, while in the ward, the sedated patient is rolled sideways on to a tough muslin sheet which becomes a stretcher when wooden poles are slipped through the longitudinal loops on each long side. The patient is then gently lifted and transported to the anteroom. On this same stretcher he is then moved by orderlies to the operating table. The poles are removed, but the muslin remains during surgery.

I found a propensity for the use of epidural block anesthesia, often with the catheter left in place during the initial 48 hours postoperatively for pain relief injections without respiratory depression. However, the full gamut of anesthetic techniques are employed. The British take justified pride in their contributions to anesthesia. Nurses have never given anesthetics in the U.K.; it has always been a physician responsibility.

### Nursing Care

Upon completion of surgery, the poles are again threaded up, the stretcher reactivated, and the transportation sequence reversed. In the anteroom, the anesthesiologist supervises the recovery. At the appropriate time, the head nurse (respectfully called Sister) comes from the ward for the patient. She chats with the Consulting Surgeon regarding the operative findings and the patient's



prognosis. Routine orders are communicated verbally; special orders are recorded on the doctor's order sheet. The Sister then accompanies the patient back to *her* ward, in which she takes possessive pride. Next she seeks out the family, explaining in lay language what has been done and what they might expect. The family relates well to the nurse, looking to her for progress reports during the ensuing postoperative days. Never are there phone calls from the family directly to the surgeon. Only with life-threatening complications or diseases does the nurse ask one of the physicians to talk with the family.

I was impressed by the youthfulness (about 25 years of age) of supervisory nurses, in the theatre and on the ward. I learned of British respect for talented youth and the recognition that youthful years are often years of deep dedication. Thus, qualified young nurses admirably shoulder major responsibilities.

A head nurse may earn 90 pounds a month, after tax deductions, approximating the earnings of postmen and policemen. She often works a split shift. She counsels the patient's family, advances the diet, is entirely responsible for the patient's bowels (she would be insulted by an order for either an enema or a laxative), she removes the sutures and manages any wound infection. In truth, she hovers protectively over her patients. Her ability to convey to the ill a sense of security is extremely meaningful.

It is unfortunately true that the Nightingale tradition is slowly being eroded. Until three years ago, the number of applicants to each London nursing school exceeded the number of openings. Not so any longer, and this is a source of concern. However, the dedication of those women who do enter and complete nurses training seems to remain unaltered.

During surgery the watchful scrub nurse seems to preempt the surgeon's requests. This was particularly appreciated by me, because of my unfamiliarity with the names of the available instruments. Cautery is extraordinarily popular, activated by hand and is kept in a neat, sterile rubberized quiver when not in use. It is a great time-saver. The persistent humidity of the British Isles probably reduces operative explosion risks.

As for medical specifics, I learned that a simple mastectomy is now routine for breast cancer, with selective postoperative radiotherapy. Intractable peptic ulcer disease is usually managed by vagotomy and a drainage procedure. Carcino-

ma of the low rectum requiring abdominal-perineal resection is handled by simultaneous two-team approach (an abdominal surgeon and a perineal surgeon). Some curious Victorian attitudes came to light. Yes, despite the Beatles, and despite avant garde British cinema, both patients and physicians usually referred to rectal bleeding as "bleeding from the back passages." Surprisingly, there is rarely, if ever, any discussion as to the sexual implications of any surgery.

Colostomies are not irrigated. Disposable stick-on neat colostomy bags are worn. Indeed, much of the disposable equipment, including syringes, needles and intravenous tubings, were of an unusually high quality. Disposable syringes were transparently clear, with pistons that moved easily within the barrel, almost like our glass syringes.

Blood and plasma are used freely. Our concern for hepatitis is enigmatic to the British. All blood is donated gratis; none is commercial. The thought that one should be paid to help a fellow-citizen is abhorrent. Perhaps here is another insight into British moral sense and into the success of their National Health Scheme.

I did not immediately detect that their glucose and saline solution was quite different from ours, until an electrolyte imbalance failed to respond. I then learned that glucose and saline in the U.K. is 4.5% glucose and 0.18% saline.

The large wards contain approximately 20 comfortable curtained-off old-fashioned beds and a central nurses desk (Fig. 2). One is impressed by the absence of gadgetry. Nasogastric tubes are irrigated and aspirated hourly by the nurse. When the aspirated volume from a postoperative patient is low enough, the nurse on her own initiative begins oral feedings of clear liquids. She determines how well the stomach is accepting these feedings and she determines when to increase them further.



Fig. 2.—Male surgical ward with central nurses station.



There is no IPPB machinery, rather there is a unique core of physiotherapists (having had 3 years of training) who visit the patient three to six times a day. With hands on the rib cage, they teach the patient to expand the side splinted after abdominal surgery.

Frequent visits of the nurses to manipulate the nasogastric tube and frequent visits of the physiotherapists to help clear the chest, provide the patient with periodic bedside visitations. The patient is never left to feel machine-connected or abandoned. Besides, the patient is, at all times, part of a large 20-bed ward and is able to see the coming and going, always available, nurses. Such care is humanistic—socialized or not!

Suspect phlebitis patients are often screened using I-125 fibrinogen, and when appropriate a venogram for confirmation. Anticoagulants are regulated by the pathologist in charge of the clinical laboratory. He organizes the blood testing, the dosage, and the timing of anticoagulant drug administration.

A superb Intensive Care Unit of three beds was completely run by the anesthesiology team. Anesthesiologists are the experts in electrolyte disturbances and in arterial gas interpretation. They salvaged some exceedingly poor risk situations. They taught me the safety and value of pre-stretching plastic tracheostomy and endotracheal cuffed tubes by placing them in sterile water (90° C, inflated with 30 cc of air for 10 minutes).<sup>2</sup> They use a drop of methylene blue in their CVP lines (to facilitate readings) and 10 mg heparin in each 500 cc to avoid clotting. In cardiac arrest situations they employ a liter solution that contains 1,000 mg sodium bicarbonate, giving 200 cc stat, and then, carefully titrating the arterial pH.

The level of competency of the Consultants in provincial hospitals is superb, as explained previously. Long years of training and intensive competition create Consultants who are of superior grade wherever they may be appointed. Currently, there is a uniformity of care throughout the British Isles that is admirable. The British system may lack the peaks of care that we proudly enjoy in major centers in this country, but they do not suffer the contrasting ebbs either. At no time did it seem to me that any patient's recovery was in the least jeopardized by a system of care that is socialized, budget-restricted, tradition-bound, and delivered in Victorian-aged buildings.

Furthermore, the homogeneity and interchangeability of people of equal expertise helps make the British National Health Service tick. For instance, there were several separate night calls to the casualty room (emergency room) for road accident victims. On none of the occasions were the same personnel present. Yet, upon my arrival, I would find the patient surrounded by a half dozen physicians and a couple of nurses. On removing my raincoat (evening showers usually), I would introduce myself to the obvious supervisory nurse, indicating I was the locum Senior Registrar. Immediately, one of the physicians would step forward, introduce himself as the Surgical House Officer (my immediate junior), and proceed with an appropriate clinical resume. I would be introduced to the others, the Casualty House Officer, the Orthopaedic House Officer, and not uncommonly the Orthopaedic Registrar (he was usually older and in a flannel suit and jacket, rather than in a white coat). There might be several medical students and the x-ray technician as well. My primary responsibility was to reinforce the Surgical House Officer, to deal with shock, and to rule out any intra-abdominal catastrophe. The faces were different each time, yet the assumption of the appropriate responsibility by each and the ability each time for the diverse physicians to work as a team impressed me tremendously. While in our country, we learn to adjust to the varying personalities of each of our referring physicians, the British, on the other hand, have mastered the art of uniformity and interchangeability of personnel.

Additionally, the British seem to have developed a technique of delegating responsibility. This seems true throughout all British life. It diffuses pressures so that no one key person is simultaneously confronted by multiple crises demanding his instant attention.

Uniformity pervades other facets of British life. Every taxi looks quite like the other. Every double-decker bus looks like every other bus. Every policeman throughout the United Kingdom has a common training and wears a common uniform. Every road sign has the same coloring and print. Such uniformity is soothing and reassuring, leaving one after awhile with a sense of "cultural" security. Consequently, a uniform protocol, reinforced by a homogeneity of goals and of life styles, plus a pervading sense of fair play and a preservation of aplomb converts potential crises to routines.

Yet, individuality is by no means completely

stified. In outpatient sessions and operating room, the individual surgeon treats his patients as he deems best, without concern about review of his work by others. There are no mortality conferences nor morbidity reviews; there are no grand rounds; there are no Utilization or Peer Review Committees. His day is filled with responding to the public's expectations (delivery of health care) and not to his peer groups' desires (meetings, research, and professional demands of various sorts). There are, of course, occasional sophisticated professional medical meetings, but not obligatory ones and not within just one hospital, but rather somewhere central to several hospitals. There are no autopsies except as needed occasionally by the Medical Examiner to complete the death certificate.

### Evaluation

Are the doctors happy? Many have known no other system. British doctors were unhappy enough to threaten a strike a year ago, resulting in a 15% wage increase. During the "non-cooperation" they refused to participate on committees of the National Health Service. They also, refused to fill out forms for patients to receive Social Security benefits.

Are the patients happy? Perhaps not entirely. However, they are not intensely unhappy and are willing to tolerate some inconveniences "because care is free." Many complain about the government's new 20 pence prescription fee (Fig. 3). Patients wait on wooden benches in the courteous, hospital Outpatient Clinics, are seen by appointment, and only upon written referral from their General Practitioner. General Practitioners have no hospital privileges. They do a busy office practice and make house calls. Their days are occupied filling out forms for referral to the hospital and for sickness benefits.

After completing an outpatient session, seeing about 20 patients in two and a half hours, I would dictate (to one of the hospital secretaries) a letter to each referring General Practitioner. All hospital notes and outpatient notes are handwritten. Only these letters and the brief discharge summaries are dictated and typed. Operating room notes are usually handwritten. Notes are British brief; five sentences usually suffice.

What about bed utilization? Many procedures which in the States would be undertaken under local anesthesia as an outpatient are performed under general anesthesia as an inpatient.

All hematuria patients received cystoscopy under general anesthesia, and as inpatients. There is a pervading awareness of the waiting list for admission but there is a counterbalancing reluctance to discharge a postoperative patient before he is truly ready, either for his own home or for a nursing home facility. No government pressure to discharge patients was evident. The British waiting list problem has received bad press in the United States. In fact, there is a waiting list for hernia, varicose vein and hemorrhoid surgery. Acceptance of the Fegan<sup>3</sup> injection technique has somewhat decreased inpatient vein surgery. Likewise, hemorrhoids are managed maximally on an outpatient basis by injections. Our hospital waiting list, which was essentially a hernia list, was only three months behind, though I understand that provincial hospital lists are indeed, longer and more varied.

Private health insurance has been purchased by some 3 million Britishers, often upper income business executives who want to select their own doctors, control the precise time of visits and the date of surgery. They enjoy the daily attention of a Consultant rather than a House Officer. Al-

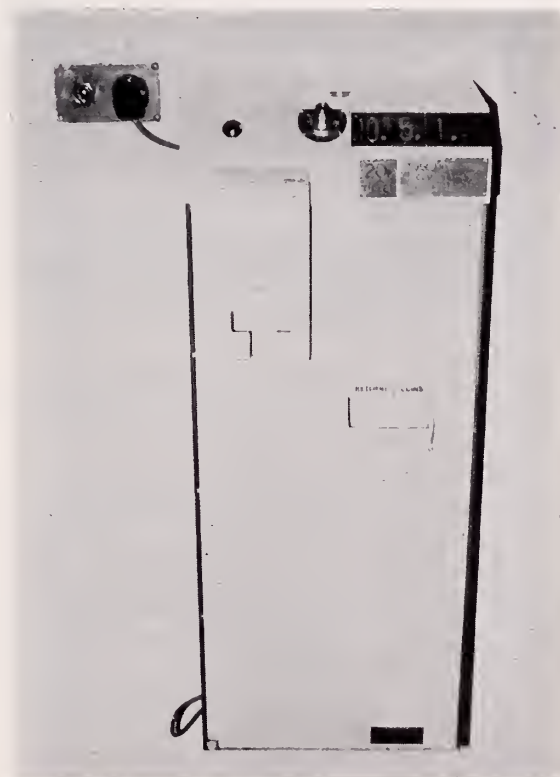


Fig. 3.—Automatic machine for 20 new pence prescription stamp. All prescriptions cost the patient 20 new pence.

though the surgeon may charge whatever he chooses, the insurance company offers only three surgical fees: one for minor surgery, one for major surgery, and a third intermediary fee. Private patients may have to supplement the difference.

Although patients within the National Health Scheme are not seen daily, but rather three times a week by the Consultant, they may be seen twice a day by the house staff. It is my opinion that patients within the National Health Scheme often receive the better nursing care. Private patients' nurses contracted through agencies are not always found to be as dedicated as N.H.S. nurses. Also, private patients were sequestered in small rooms, away from the comings and goings of available ward personnel. About 10% of the hospital beds in the United Kingdom are for private patients. Half of these are within N.H.S. hospitals, the remainder being in separate private clinics.

#### Summary

In summary, the British National Health Scheme provides medical care that is good and that is uniform across the country. Physicians are well-trained; the nurses spectacularly dedi-

cated. The nature and quality of British life reflects an essential humanism which pervades their T.V., cinema, human relations, hospital interrelations and medical care. Taking into consideration the British economy, the unique homogeneity of culture and values which permit endurance of minor inconveniences, one comes away with the impression that the present N.H.S. is practical and approaches the average Britisher's expectations for health care. Precisely for these reasons I doubt that the British system could be transplanted unaltered to the U.S. It would seem that our tradition of individualism, our suspicion of authority, our plunge towards computerized dehumanization, and our internal disharmonies would jeopardize a British-type National Health Scheme for the U.S.A.

#### References

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2. Geffin, B. and Pontoppidan, H.: Reduction of Tracheal Damage by the Prestretching of Inflatable Cuffs, *Anesthesiology* 31:462-463, 1969.
3. Fegan, W. G.: Varicose Veins: Compression Sclerotherapy, 1967, Heinemann, London.

► Dr. Shocket, 1680 Meridian Avenue, Miami Beach 33139.

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**Indications:** Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms. **Important Note:** *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

**Contraindications:** Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

**Warnings:** Safety in pregnancy not established. Do not use for group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, and rexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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\*Koch-Weser, J., et al.: *Arch. Intern. Med.*, 128:399, 1971.

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### CONTRAINDICATIONS:

Hypersensitivity to any of the tetracyclines. **WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas, and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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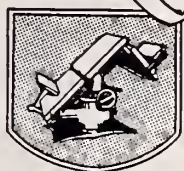
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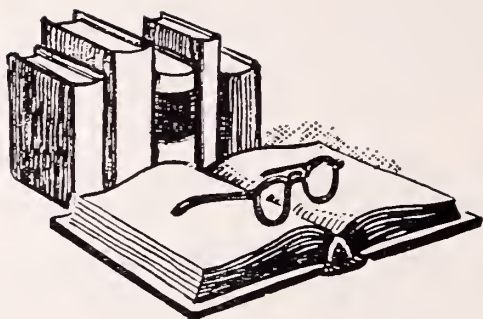
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## Book Reviews

**Pediatric Therapy**, Fourth Edition, edited by Harry C. Shirkey, M.D. Pp. 1,221. 443 illustrations. Price \$34.50. St. Louis, The C. V. Mosby Company, 1972.

Of making many books there is no end so that after three successful editions of Shirkey's *Pediatric Therapy* a fourth was not unexpected. Although this is an excellent work the new edition satisfies no long felt need; thanks to government regulatory agencies relatively few new drugs approved for use in children are now appearing in the pharmacies. Views differ regarding the desirability of vesting the Food and Drug Administration with so much authority but, rightly or wrongly, it has led to fewer, albeit safer, new pediatric drugs for general use. As the author concedes, pediatric therapy is advancing less rapidly than is adult therapy.

A textbook like Shirkey's has a role in the physician's library which differs from that of the *Yearbook*. To every thing there is a season and a spanking new edition once every five to ten years would be a publishing event worth waiting for but a slightly updated version after three years and eight months is a horse of a different color.

While it behooves everyone who treats children to have a copy of Shirkey at hand, he who owns the third edition need not cast it aside and hasten to his bookseller's for the latest model.

Although premature, this book is taller and heavier than the last edition and the price has shot up to \$34.50. If you judge a book by its beautiful turquoise cover the new trim suggests change; peruse it and you will find no extensive revision. Many chapters are reprints of the 1968 version.

So to state is not, of course, to disparage the book. What was good therapy four years ago is far from outmoded today. Would that every sick child in 1972 could be sure of getting the type of care recommended by the experts in 1968!

Moreover any edition of this work can be read or browsed with profit. Readers who have revisited Osler's textbook will recognize the same durable quality in Dr. Shirkey's writings, e.g., "Even the best treatment will seldom rectify poor diagnosis." "Often the best treatment requires no drugs at all."

The fourth edition has eighteen new contributors out of a total of ninety six and twenty of the one hundred nineteen chapters are written by Dr. Shirkey. New material has been added on the following: Parenteral alimentation, phototherapy for hyperbilirubinemia, use of hyperimmune anti D gamma globulin, oxygen therapy (and oxygen toxicity), radiation therapy, gamma globulin, with a timely reminder about its limitations, brucellosis, sarcoidosis and modification of laboratory tests caused by drugs.

The chapter on peptic ulcer has been rewritten with conspicuous omission of the page of detailed dietary instructions. Apparently pediatrics is following the recent trend of certain gastroenterologists away from rigid "ulcer diets."

The chapter on newborn special care contains some new material on low birth weight infants and a rather skimpy section on the use of positive transpulmonary pressures in the respiratory distress syndrome. Actually a full chapter on respirator therapy would have been most timely. Until these new methods are spread abroad too many distressed infants will continue to perish because of inadequate oxygenation.

At the time of going to press Dr. Gluck is still advocating the double pHisoHex bath for newborns which he introduced some ten years ago but he anticipates the hexachlorophene scare with a prescient footnote warning of possible changes.

No single volume sets out to encompass the treatment of every known disorder. This one covers an enormous number of conditions and despite its deceptively modest title is very much



more than a book of pediatric therapy. There are over four hundred instructive clinical photographs of superior quality and much of the text deals with diagnosis.

Nevertheless, there are notable deficiencies. Muscular dystrophy is dismissed in five lines. Florida physicians in particular may find the section on "Drowning" very inadequate especially when compared with the exhaustive discussion in Gellis and Kagan's textbook on "Near Drowning" and its complications. (Purists will prefer the latter term, there being no known cure for drowning so far.)

Other common conditions like cutaneous larva migrans, pityriasis alba and erythema infectiosum are not included whereas there is space devoted to such esoteric diseases as juvenile xanthoma granulosa of the iris and Harada's disease! And if treatment of malarial coma is described then why no mention of Reye's disease?

A final criticism is reserved for the careless indexing and proofreading; nothing is more irritating than consulting an index and being referred to the wrong page. We came across three of these mistakes just by random sampling!

The brown spider is called *Loxosceles reclusis* (sic) with a fine disregard for declensions which will dismay latinists and entomologists. Advocates of phonetic spelling will be delighted to find "venous thrombosis." These faults are no more than minute flaws in the marble and any animadversions must be construed not as an exercise in pedantry but merely as a time-honored reviewmanship ploy bearing witness to meticulous study of the assignment.

COLIN KENDALL, M.D.  
TEMPLE TERRACE

**PEDIATRIC CLINICAL GASTROENTEROLOGY** by Arnold Silverman, M.A., M.D., Claude C. Roy, M.D., F.R.C.P.(C), and Frank J. Cozzetto, M.D. 580 Pp., 295 illustrations. Price \$39.50. The C. V. Mosby Company, St. Louis, 1971.

This is not an exhaustive work; however, it does fulfill a need since textbooks on pediatric gastroenterology are few. References are well selected and current.

Because of the price, I doubt that this will have wide appeal for the practicing physician. I can recommend it for hospital and medical school libraries.

F. NORMAN VICKERS  
PENSACOLA

## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Cardiovascular Physiology**, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price \$9.25. St. Louis, The C. V. Mosby Company, 1972.

**Hematopoietic and Gastrointestinal Investigations with Radionuclides** by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price \$30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

**A Civilian Doctor in Vietnam** by Fred Gloeckner, M.D. Pp. 123. 27 Illustrations. Price \$5. Philadelphia, Pa., The Winchell Company, 1972.

**Malnutrition, Its Causation and Control**, Volume I and II by John R. K. Robson. Pp. 613. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1972.

**Current Pediatric Diagnosis Treatment**, 2nd Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. Pp. 1008. Illustrated. Price \$12.00. Los Altos, California, Lange Medical Publications, 1972.

**Laboratory Medicine Hematology**, Fourth Edition by John B. Miale, M.D. Pp. 1318. 1399 Illustrations. Price \$27.50. St. Louis, The C. V. Mosby Company, 1972.

**Symposium on Aesthetic Surgery of the Face, Eyelid, and Breast**, Volume Four. Edited by Frank W. Masters, M.D. and John R. Lewis Jr., M.D. Pp. 222. 446 Illustrations. Price \$35.50. St. Louis, The C. V. Mosby Company, 1972.

**A Laboratory Manual for Exercise Physiology** by Donald J. Byrd, Ph.D. and Freddie M. Browning, Ph.D. Pp. 158. Springfield, Illinois, Charles C. Thomas Publisher, 1972.

**Developments in Horney Psychoanalysis** edited by Jack L. Rubins, M.D. Pp. 335. Price \$12.50. Huntington, New York, Robert E. Krieger Company, 1972.

**Handbook of Medical Treatment** edited by Milton J. Chatton, M.D. Pp. 648. Price \$6.50. Los Altos, California, Lange Medical Publications, 1972.



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Wordsworth

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## Deaths

**Astler, DeWitt G.**, Winter Park; born 1898; Eclectic Medical College, 1921; member AMA; died August 24, 1972.

**Barge, Hubert A.**, Miami; born 1896; Vanderbilt University, 1922; member AMA; died October 20, 1972.

**Clardy, Ed R.**, Ocala; born 1902; member AMA; died May 12, 1972.

**Cumming, Richard C.**, Ocala; born 1902; Johns Hopkins University, 1928; died October 11, 1972.

**Deen, Oliver F. Jr.**, Tampa; born 1917; University of Georgia, 1944; member AMA; died October 2, 1972.

**Eisenman, Leon S.**, Hialeah; born 1908; Loyola University, 1933; member AMA; died October 9, 1972.

**Friend, LeRoy F.**, Daytona Beach; born 1902; University of Washington, 1930; member AMA; died March 17, 1972.

**Knowles, Harold S.**, Orlando; born 1908; Rush University, 1936; member AMA; died August 31, 1972.

**Korus, Hanns C.**, Ormond Beach; born 1921; State University of Thuringia, 1944; member AMA; died August 25, 1972.

**Lewis, Alfred L. Jr.**, Tallahassee; born 1927; Tulane University, 1954; member AMA; died October 14, 1972.

**Meador, Murray W.**, Hialeah; born 1931; Kansas University Medical School, 1956; member AMA; died September 27, 1972.

**Murphy, Alvin E.**, Palm Beach; born 1905; University of Cincinnati, 1930; member AMA; died October 18, 1972.

**Palacio, Guillermo R.**, West Palm Beach; born 1904; Habana University, 1927; member AMA; died September 23, 1972.

**Pierce, LeRoy C.**, Plant City; born 1924; Bowman Gray School of Medicine, 1947; member AMA; died October 7, 1972.

**Robson, Frank Y.**, New Port Richey; born 1911; Emory University, 1937; member AMA; died October 8, 1972.

**Shoelson, Seymour M.**, Miami; born 1936; Washington University and Miami School of Medicine, 1962; member AMA; died September 27, 1972.

**Simendinger, Earl A.**, Tampa; born 1911; University of Cincinnati, 1937; member AMA; died September 20, 1972.

**Zarzecki, Casimer A.**, Miami; born 1917; University of Michigan, 1944; member AMA; died August 23, 1972.



# MEETINGS

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## JANUARY

- 15-20 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.
- 24-28 University of Miami Annual Seminar on Pediatric and Adult Urology, Playboy Plaza Hotel, Miami Beach. For information: Michael P. Small, M.D., Box 875, Biscayne Annex, Miami 33152.
- 26-27 Cardiology at Disney World, Contemporary Hotel, Disney World, Lake Buena Vista, Florida. For information: Shelburn Wilkes, 12 West Columbia, Orlando 32806.
- 28-31 Selected Topics of Cancer Management, Americana Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.

## FEBRUARY

- 11-16 Eighth Annual Postgraduate Course "Internal Medicine 1973," Sheraton Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33153.
- 19-21 Ear Surgery Course, St. Joseph's Hospital, Tampa. For information: J. Brown Farrior, M.D., 509 Bay at Bayshore Blvd., Tampa 33606.
- 19-24 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## MARCH

- 14-17 Fifth Teaching Conference in Clinical Cardiology, Sheraton Four Ambassadors Hotel, Miami. For information: Michael S. Gordon, M.D., Box 875, Biscayne Annex, Miami 33152.
- 19-24 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## FEBRUARY

- 4-10 Midwinter Seminar in Ophthalmology and Otolaryngology, Americana Hotel, Miami Beach. For information: Kenneth S. Whitmer, M.D., 550 Brickell Ave., Miami 33131.
- 25-Mar. 3 Contemporary Medicine and Surgery, Fontainebleau Hotel, Miami Beach. For information: John Bellows, M.D., 30 N. Michigan Ave., Chicago 60602.
- 25-Mar. 3 Contemporary Ophthalmology, Fontainebleau Hotel, Miami Beach. For information: John Bellows, M.D., 30 N. Michigan Ave., Chicago 60602.

## MARCH

- 11-15 International Anesthesia Research Society, Americana Hotel, Miami Beach. For information: B. B. Sankey, M.D., 3645 Warrenville Center Rd., Cleveland 44122.

## MAY

- 3- 5 Association of Clinical Scientists, Hawaiian Village, Tampa. For information: F. William Sunderman Jr., M.D., University of Connecticut School of Medicine, Drawer B, Newington 06111.
- 3- 7 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. For information: Robert D. Reinecke, M.D., Albany Medical College, Albany, N. Y. 12208.
- 6-12 American Society for Microbiology, Fontainebleau Hotel, Miami Beach. For information: Mr. R. W. Sarber, 1913 I St., N.W., Washington, D. C. 20006.
- 12-14 American Association of Blue Shield Plans, Diplomat Hotel, Hollywood, Fla. For information: Jean A. Borger, 211 E. Chicago Ave., Chicago 60611.
- 21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

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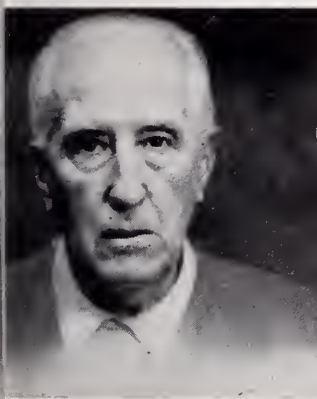
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VOL. 60, NO. 2

MDS

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

FEBRUARY 1973







Everybody experiences psychic tension.



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**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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FEBRUARY COVER—Artist's conception of Copernicus by Mr. Michael Schlazer, painter, illustrator and teacher, of Miami. See article, "Copernicus Remembered," page 32.



## President's Page



### What Is Your Medical Society Doing?

Questions concerning the role of the medical society are often raised. Many of you probably have only a vague idea of the workings of your medical society. There are undoubtedly many activities and programs underway in each society, and progressing from the county, to the state, to the national group; the scope of the programs undertaken naturally increases. We have just completed what I believe to be a very worthwhile two-day conference in Orlando, attempting to keep our component societies and officers up-to-date. This was the 15th annual Leadership Conference for County Medical Society Officers, and was held at the Kahler Plaza Inn on Saturday and Sunday, January 27-28, 1973. I had the privilege of presiding over the morning session, with the lead-off subject being "FMA 1973 Legislative Program." Dr. Louis C. Murray covered this field, and again displayed his indepth knowledge of medical legislation related to health care in our State.

Next, a joint presentation by Dr. James L. Borland Jr. and Dr. James B. Byrne, covered the subjects of Foundations for Medical Care, HMOs, PSROs, and FMA Peer Medical Utilization Review programs. Mr. Emmett Roberts, who is Secretary of Florida's Department of Health and Rehabilitative Services, gave us insight into some of the many programs and problems of his vast department. Dr. Vincent P. Corso reported to us from our Judicial Council on the role of the county medical society in membership and discipline and ethics.

For the past many years, it has become traditional for Dr. Ernest B. Howard, Executive Vice President of the American Medical Association, to discuss national medical affairs at our luncheon. This year was no exception, and Doctor Howard's remarks were most interesting and timely.

The afternoon session was chaired by Dr. Joseph C. Von Thron, your President-Elect, with presentations by Dr. Thomas B. Thames and Dr. David Kindig on "National Health Service Corps." Dr. James T. Cook, president of our newly-formed Florida Physicians Association, Inc., reported on the progress of this recently chartered organization and urged participation by our membership.

A change of pace was enjoyed when our Auxiliary president, Catherine (Mrs. James J.) DeVito, told of her upcoming health education workshop planned for March. This should be a most worthwhile endeavor.

Dr. Robert Windom discussed voluntary health agencies and their importance at county level, followed by Dr. Michael J. Pickering explaining to us his committee's plans for continuing medical education. Dr. Roy M. Baker told of the work of the Emergency Medical Services Committee in Florida, and we were all impressed by the activity of his group. The Sunday morning session from 9 a.m. to 1:30 p.m. was a most informative Legislative Seminar, bringing us information on both state and national legislative problems and programs.

With this as background material, it must be now apparent to you that if your officers did attend our meeting, they are well aware of what is going on. This FMA Conference has been a most successful program over the past years, and the AMA has now picked up the ball and is planning its first AMA National Leadership Conference for February 16-18, 1973, in Chicago. I am looking forward to attending this national meeting, along with Drs. Joe Von Thron and James W. Walker and Mr. Harold Parham. I hope we will be able to contribute and bring back information that will be helpful to us here in Florida.

It would seem to me to be most worthwhile if your own county medical society officers would conduct an open town hall type meeting with their membership so that questions concerning organized medicine could be answered on a local level. Communication remains our greatest problem and I would hope that each of you would take the time and make the effort to try to be well informed on the many problems and new programs that seem to be cropping up monthly.

*William J. Dean, M.D.*

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# Hunger Control VS. Weight Control

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S. K. Fineberg, M.D.

Clinical Assistant Professor of Medicine,  
New York Medical College.  
Chief, Diabetes and Obesity-Diabetes Clinics,  
Metropolitan Hospital, N.Y.C.  
Director of Medicine,  
Prospect Hospital, Bronx, N.Y.

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"The appropriate and proper use of anorexigenic drugs in an overall program of weight reduction is to relieve the acute symptoms which are invariably produced by a sharply lowered caloric intake."

"Their use should only be as part of an intensive program which includes patient motivation, instructions in diet, good nutrition and a knowledge of the caloric content of foods."

Preludin is indicated in exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. For full details, please see the Prescribing Information. It is summarized on the adjacent page.

\*Fineberg, S.K.: Presented at Annual Meeting, American Society of Geriatrics, New York City, April 5, 1972.

**Preludin**<sup>®</sup> phenmetrazine hydrochloride NF

---

# Preludin®

phenmetrazine  
hydrochloride

# Endurets®

prolonged-action  
tablets

---

## Preludin® phenmetrazine hydrochloride NF

**Indications:** Preludin is indicated in exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction.

**Contraindications:** Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hypothyroidism, known hypersensitivity or idiosyncrasy to sympathomimetic amines, and agitated states. Patients with a history of drug abuse. Do not use with other CNS stimulants or MAO inhibitors. Use within 14 days following the administration of monoamine oxidase inhibitors may result in hypertensive crises. **Warnings:** Tolerance usually develops within a few weeks. When it occurs, the recommended dosage should not be exceeded in an attempt to increase anorectic effect.

**Drug Dependence:** Tolerance and extreme psychological dependence have occurred. Patients have been known to increase the dosage of drugs of this type to many times the recommended dosage. Abrupt cessation following prolonged high dosage results in extreme fatigue, mental depression, and reversible changes in the sleep EEG. Manifestations of chronic intoxication include severe dermatoses, marked insomnia, irritability, hyperactivity and personality changes. The most severe manifestation is psychosis, often clinically indistinguishable from schizophrenia.

Caution patients on the possibility of impaired ability to operate machinery or drive a motor vehicle or engage in other potentially hazardous activity.

**Use in Pregnancy:** There have been clinical reports of congenital malformation associated with the use of this compound but a causal relationship has not been proved. Until more information is available, Preludin should not be used by women who are or may become pregnant, particularly in the first trimester, unless the physician feels potential benefits outweigh possible risks.

**Use in Children:** Not recommended for use in children under 12 years of age.

**Precautions:** Use with caution in patients with mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with anorectic agents and concomitant dietary regimen. Psychological disturbances may occur in some patients on a restrictive diet with or without concomitant use of an anorectic agent.

**Adverse Reactions:** Overstimulation, restlessness, insomnia, anxiety, headache, agitation, flushing, tremor, sweating, dizziness,

ness, dryness of the mouth or unpleasant taste, urticaria, gastrointestinal disturbances, nausea, diarrhea, palpitation, tachycardia, elevation of blood pressure, urinary frequency, dysuria, and changes in libido. Psychotic states at recommended dosage have been reported with related drugs.

**Dosage and Administration:** One 25 mg. tablet b.i.d. or t.i.d. one hour before meals, or one 50 mg. or 75 mg. Endurets prolonged-action tablet taken daily. Not recommended for children under 12 years of age.

**How Supplied:** For b.i.d. or t.i.d. administration, pink, square, scored tablets of 25 mg. in bottles of 100 and 1000.

For once-a-day administration, white, round Endurets prolonged-action tablets of 50 mg. in bottles of 100, and pink, round Endurets prolonged-action tablets of 75 mg. in bottles of 100 and 500.

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For complete details, please see the full prescribing information.  
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# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions

# A New Dosage Form:

## Chewable Tablets 500 mg Mintezol<sup>®</sup> (THIABENDAZOLE | MSD)



so easy to take  
everyone in the family  
can keep to the  
regimen you prescribe

include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.  
Supplied: Chewable tablets, containing 500 mg thiabendazole, in boxes of 36, strip packaged, individually foil wrapped; suspension, containing 500 mg thiabendazole per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19386

## INDICATION | DOSAGE SCHEDULE

MINTEZOL<sup>®</sup> (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	1/2
50	0.5	1
75	0.75	1 1/2
100	1.0	2
125	1.25	2 1/2
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

## **Medical News**

### **Florida Governors Chosen by ACS**

Three members of the Florida Medical Association have been elected to three-year terms on the Board of Governors of the American College of Surgeons.

Richard C. Clay, M.D., of Miami, was elected at the Clinical Congress of ACS, which was held in San Francisco. Re-elected were Richard G. Connar, M.D., and Hawley H. Seiler, M.D., of Tampa.

### **Certified in Medicine**

Robert M. Williams, M.D., of Vero Beach, has been certified by the American Board of Internal Medicine.

### **Cancer Society Elects**

Three members of the Florida Medical Association have been elected to top offices in the Florida Division, American Cancer Society.

Malcolm S. Van de Water, M.D., West Palm Beach radiologist, was elected President of the Florida group. Vice Presidents include Martin Gould, M.D., Vero Beach, and Joseph K. Isley Jr., M.D., Ft. Myers.

### **Governor Names Dr. Ruffin**

Gov. Reubin Askew has appointed William C. Ruffin Jr., M.D., of Gainesville to represent Florida on the Southern Regional Education Board's Commission on Mental Illness and Retardation. Dr. Ruffin is Professor and Chairman of the Department of Psychiatry, University of Florida College of Medicine.

### **Dr. Threlkel Elected**

Robert H. Threlkel, M.D., of Jacksonville has been elected a Fellow of the American Academy of Pediatrics.

### **Eye Institute Receives Grant**

The Bascom Palmer Eye Institute of the University of Miami School of Medicine has received a grant of \$60,000 from the Walter G. Ross Foundation of Washington, D.C.

According to Institute Director Edward W. D. Norton, M.D., the grant has been allocated to the Institute's research program, particularly in the area of diabetes and retinal diseases.

### **Congress on Medical Education**

The American Medical Association's 69th Annual Congress on Medical Education will be held at the Palmer House in Chicago, February 9-11.

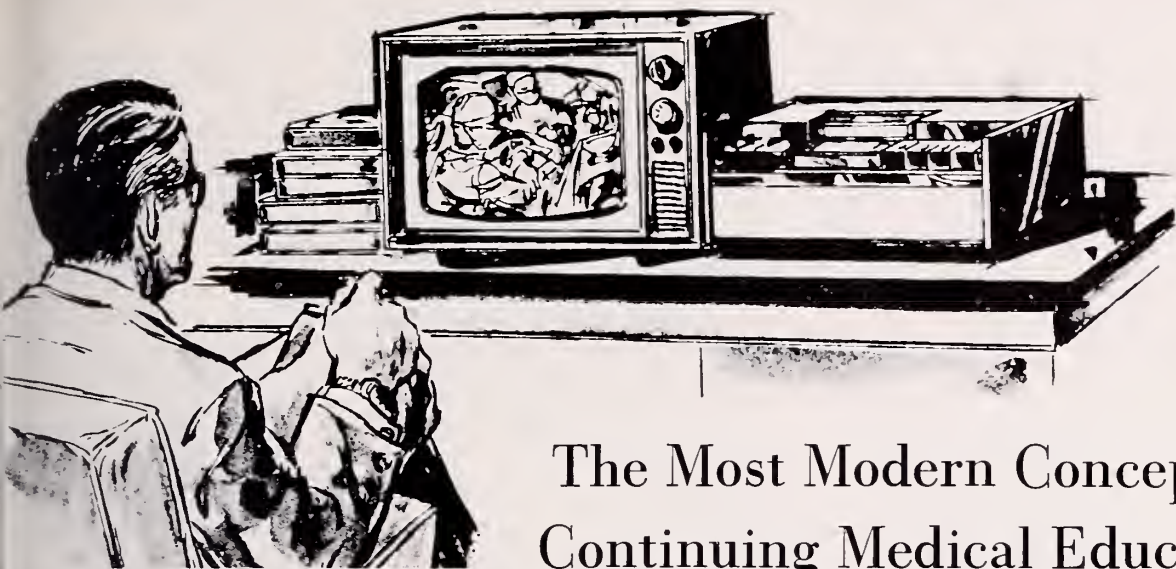
Programs and information may be obtained by writing to: Secretary, Council on Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

### **Congress on Medical Ethics**

The Fourth National Congress on Medical Ethics will be held at the Washington-Hilton in Washington, D.C., April 26-28, 1973.

Information may be obtained by contacting: The Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.





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# Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

- infected burns, skin grafts, surgical incisions, otitis externa
- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

## NEOSPORIN<sup>®</sup> Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

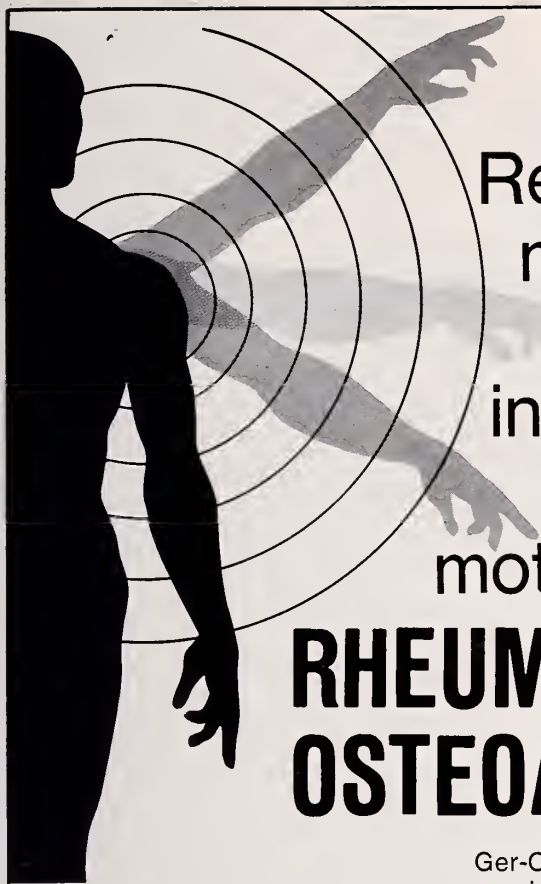
Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and ⅓ oz. (approx.) foil packets.



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North Carolina 27709





Relief from  
minor pain  
for  
increased  
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motion in

# RHEUMATOID and OSTEOARTHRITIS

Ger-O-Foam, when massaged into the skin, provides increased range of motion by decreasing pain in joints affected by rheumatoid or osteoarthritis. "As a surface analgesic it enhances the usefulness of massage by reducing pain, thus permitting functional exercises otherwise impossible to administer."<sup>1</sup> Ger-O-Foam's surface analgesic-anesthetic foam relieves minor pain fast and lasts for long periods of time.

**PRECAUTIONS:** Do not use in or near eyes, on open wounds or mucous membranes. Discontinue if excessive irritation of the skin develops.

**AVAILABLE:** 1½ and 4 oz. cans. Approximately 125 applications in each 4 oz. can.

1. Gordon, E. E. and Haas, A.,  
Indust. Med. & Surg. 28:217, May, 1959.

## GER-O-FOAM<sup>TM</sup> AEROSOL FOAM FOR MASSAGE

methylsalicylate 30% and benzocaine 3% in a specially processed emulsion

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**PRESCRIBING INFORMATION  
Antiminth (pyrantel pamoate) Oral  
Suspension**

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

**Precautions.** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

**How Supplied.** Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

**ROERIG Pfizer**

A Division of Pfizer Pharmaceuticals  
New York, New York 10017

# Clean Sweep



## with a single dose of Antiminth

(pyrantel pamoate) ORAL SUSPENSION

Highly effective against  
pinworm and roundworm

Non-staining to teeth  
or oral mucosa on ingestion, to  
tools, clothing, linen

Simple dosage with a  
single-dose regimen: 1 cc. per  
10-lb. body weight (1 tsp./50 lb.;  
maximum dose, 4 tsp.)

Well-tolerated, based on  
clinical studies\*

Pleasant-tasting, easy-to-  
take, caramel-flavored oral  
suspension

Economical, because one  
prescription can treat the entire  
family

**ROERIG** *Pfizer*

A division of Pfizer Pharmaceuticals  
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# ANTIMINTH<sup>®</sup>

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

While Antiminth is highly effective against pinworms and roundworms, the illustration is not meant to imply 100% efficacy.  
\*Data on file at Roerig. Please see prescribing information on facing page.

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practice  
medicine in the  
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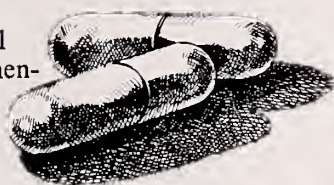


**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition.

Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis**

**adjunctive Librax®**

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

LA13H

# FEEDBACK -from Pearl Street

## Influenza Up-Date (12 Jan.)

Influenza-like disease activity is at a low-almost surprisingly low-level in Florida to date. Foci of acute upper respiratory disease have been documented in several places, including the Broward, Manatee, and Volusia County areas among others; but these have not been accompanied by the excess mortality usually associated with influenza A outbreaks, nor has epidemic-type rapid transmission been seen. Serologic evidence continues to demonstrate the general absence of influenza A and B. Since last month, 69 sets of paired sera from all over the state have been tested at the Division of Health and only one case of influenza A disease has been documented for the current flu season. That case is a 23-year old man from Dade County who was hospitalized with fever, malaise and electrocardiographic evidence of myocarditis; he presented no evidence of respiratory tract disease. An occasional case of adenovirus infection and several isolated cases of *Mycoplasma pneumoniae* infection have been confirmed, but the vast majority of sera do not react to the standard battery of respiratory antigens. Although all of these patients had an influenza-like syndrome, the most probable etiologic agent is rhinovirus (cold virus). In any case, we do not have true influenza as a public health problem in Florida at this time.

After the original civilian outbreak of influenza A in the Baltimore-Washington area in December, this disease has achieved some prominence in several other states including Massachusetts, Ohio, Virginia, Hawaii, Tennessee and Georgia. Hawaii is the only state currently reporting both influenza A and B. Influenza A strain minor variants, as exemplified by A/England/42/72-commonly referred to as "London flu" in the lay press-have caused some of this activity. However, no severe problem such as occurred during the major antigenic shift and emergence of A<sub>2</sub>Hong Kong influenza has yet been reported.

## Hepatitis A—

We are currently experiencing widespread and multi-focal outbreaks of hepatitis A (infectious hepatitis, short incubation period hepatitis) in much of the state. In several situations where case clusters have been reported, detailed field

epidemiological investigations have been requested and accomplished. A major hospital, an elementary school, two day-care centers and one entire county have successively hosted recent case clusters of hepatitis A. This pattern of transmission has been person-to-person via the usual fecal-oral route, and no outbreaks of a common food source character have been identified. Some of the clustering appeared coincidental, though much of it represented secondary or tertiary spread from other cases. Immune serum globulin (ISG) use has been appropriate for the most part, but several instances of excessive or otherwise imprudent use have been noted. When ISG prophylaxis is not restricted to early use in intimate contacts of known cases, it can be a factor actually aiding in the transmission of hepatitis A, thus having the opposite effect than that for which it is intended. Inappropriate ISG use tends to beget new cases, by masking infection in contacts of cases and allowing these people to become infectious for others while not identifiably ill themselves. Normal activities are pursued and the circle of transmission widens exponentially. ISG has no place in the prevention of hepatitis B (serum hepatitis, long incubation period hepatitis, or HAA-positive hepatitis).

## Florida Red Tide—

Paralytic shellfish poisoning as a result of red tide was discussed on this page in November. Since then, the southeastern coast of the state has experienced a red tide and some associated unusual human illness. An outbreak of acute eye and upper respiratory irritation accompanied the *Gymnodinium breve* red tide and is thought to be a result of exposure to toxic components of these micro-organisms as they were broken up in the rugged surf and aerosolized in ocean spray. Symptoms appeared when the wind blew in from the ocean and affected nearly everyone on the beach. Persons with pre-existing asthma, emphysema and chronic bronchitis seemed to be more severely affected than those with uncompromised respiratory systems who had the same exposure. Symptoms abated immediately upon leaving the beach in most instances. A few persons had prolonged exposure (by dint of work or stubbornness) and suffered lingering symptoms even after leaving the area, but responded well to supportive therapy.





in the glaucoma patient  
in cerebral or peripheral  
vasodilator therapy  
**no treatment  
conflict  
reported**

# **VASODILAN<sup>®</sup>**

**ISOXSUPRINE HCl)**  
the compatible vasodilator

- no reported increase of intraocular pressure
- conflicts have not been reported with miotics, corticosteroids, antihypertensives, hypoglycemics or diuretics

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**INDICATIONS:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**COMPOSITION:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**DOSAGE AND ADMINISTRATION:** 10 to 20 mg. three or four times daily.

**CONTRAINDICATIONS AND CAUTIONS:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**ADVERSE REACTIONS:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**SUPPLIED:**

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## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

**Photosensitivity** manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema. **PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days. **SUPPLIED:** Rondomycin (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information

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## Various Tests in the Evaluation of Islet Cell Adenomas

WILLIAM M. I. SCHMIDT, M.D.; GERALD S. LEVEY, M.D., AND  
DANIEL H. MINTZ, M.D.

**Abstract:** The evaluation of a patient with a functioning islet cell adenoma is reported. The variability of provocative tests in patients with this disorder emphasizes that no single test can be relied upon. This report concluded that despite numerous provocative tests available, several fasting sugars combined with simulta-

neous plasma insulin levels will most often provide the correct diagnosis. Occasionally, prolonged fasting is required. The use of blood sugar: insulin ratio during the fasting period may considerably shorten the extent of the fast required. The potential role of proinsulin in the diagnosis of these tumors is discussed.

Since the description by Wilder and co-workers of a malignant metastatic carcinoma of the pancreas associated with symptoms of hypoglycemia<sup>1</sup> and the subsequent report<sup>2</sup> of surgical cure in a similar case, a great deal of interest has centered on reliably identifying patients in whom a functioning islet cell tumor is present. Whipple proposed<sup>3</sup> the diagnostic triad of symptomatic hypoglycemia, fasting blood glucose concentration less than 50 mg.% and immediate relief of symptoms following glucose infusion. These criteria, however, were applicable to hypoglycemia of other diverse etiologies and more specific diag-

nostic aids were sought. Accordingly, additional methods were developed in the hope that they would accurately identify patients with functioning islet cell tumors. These included the 72-hour fast<sup>4</sup> as well as provocative tests with intravenous tolbutamide,<sup>9-11</sup> l-leucine,<sup>4-8</sup> and intravenous glucagon.<sup>12-14</sup> More recently, the application of reliable assays for immunoreactive insulin<sup>15</sup> and proinsulin<sup>16</sup> have offered promise of providing even more specific and sensitive diagnostic aid.

This report notes our experience with some of these tests in a patient in whom the diagnosis of insulinoma was initially suspected and ultimately proven by surgical exploration. The variability of responses to provocative testing emphasizes that no single test can be relied upon to establish the diagnosis. Moreover, our experience with this patient does suggest that elevated fasting plasma insulin associated with spontaneous hypoglycemia is a specific indication of the presence of an islet cell adenoma.

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Dr. Schmidt is a Fellow in Endocrinology and Metabolism, Dr. Levey Associate Professor of Medicine, and Dr. Mintz Professor of Medicine and Chief, Division of Endocrinology and Metabolism, University of Miami School of Medicine, Miami.

## Case History

The patient, a 58-year-old white man, was referred to the University of Miami for evaluation of hypoglycemia. Thirteen years previously he had undergone removal of a frontal lobe meningioma and did well until 11 years later when the first of multiple episodes of disturbed consciousness began. These episodes, unrelated to the time of day, varied from momentary lapses of attention to prolonged periods characterized by open eyes, inappropriate conversation, and unresponsiveness to verbal stimuli. In 1969, phenobarbital and dilantin were begun and continued until the present admission with little relief of symptoms. In January 1971, a plasma glucose concentration of 28 mg.% was obtained during such an attack. Continuous infusion of dextrose was required to maintain normoglycemia.

On examination the patient had a dulled sensorium and limited attention span. He appeared poorly nourished and had a blood pressure of 120/80 mm. Hg., pulse rate of 80 per minute and regular, and normal temperature. The liver edge was palpated 2 cm. below the right costal margin with a total hepatic span of 15 cm. in the mid-clavicular line. Tobacco stained finger nails and atrophy with weakness of the thenar and hypothenar muscles were also noted. The balance of the physical examination was normal.

Initial laboratory data were normal except for a fasting blood sugar of 50 mg.%. Chest x-ray, plane film of the abdomen, intravenous pyelogram, pancreatic and liver scan, skull and GI series were normal.

Provocative tests with l-leucine, 150 mg./kg. orally, tolbutamide, 1 Gm. intravenously, and glucagon, 1 mg. intravenously were performed on successive days (Table 1). Blood was also ob-

tained during a one-hour fast. All specimens from these procedures were analyzed for blood glucose concentration and plasma immunoreactive insulin. Plasma proinsulin determinations were also obtained on selected fasting blood samples.

Due to the patient's inability to maintain normoglycemia without constant glucose infusion, oral therapy with diazoxide, a benzothiadiazine derivative with hyperglycemic properties<sup>17</sup> was begun. Administration of this drug was associated with return of the blood sugars to normal and improved mental status. Later, in spite of the failure of celiac angiography to demonstrate a tumor, exploratory laparotomy was performed. An islet cell adenoma, 1 cm. in diameter, was located in the distal one-half of the pancreas. Postoperatively, the blood sugar remained within the normal range without any medication.

## Results

Administration of tolbutamide induced a fall in plasma glucose concentration from 45 mg.% to 20 mg.% over 15 minutes with values remaining at this level for the remainder of the test. Simultaneously, the concentration of plasma insulin rose at three minutes from fasting levels of 60  $\mu$ U/ml. to 190  $\mu$ U/ml., fell to 85  $\mu$ U/ml. at 40 minutes, and then showed a gradual incline to 135  $\mu$ U/ml. at 120 minutes. We consider a test abnormal in a lean person when blood sugars fall and persist to hypoglycemic levels for 180 minutes following tolbutamide administration. Simultaneous increments in plasma insulin rise greater than 100  $\mu$ U/ml. within the first five minutes and absolute peak values exceed 200  $\mu$ U/ml. in response to the tolbutamide.<sup>18</sup>

Glucagon, 1 mg. intravenously, was associated with a rise in plasma glucose concentration from 80 mg.% to 100 mg.% at 15 minutes. Plasma

TABLE 1.—PLASMA IMMUNOREACTIVE INSULIN AND GLUCOSE RESPONSE TO PROVOCATIVE STIMULI AND FASTING.

Time (min.)	Fasting		Tolbutamide		L-Leucine (150 mg./kg. p.o.)		Glucagon (1 mg. IV)	
	Glucose (mg. %)	IRI ( $\mu$ U/ml.)	Glucose (mg. %)	IRI ( $\mu$ U/ml.)	Glucose (mg. %)	IRI ( $\mu$ U/ml.)	Glucose (mg. %)	IRI ( $\mu$ U/ml.)
0	55	60	45	60	50	50	80	55
1	—	—	45	110	—	—	—	—
3	—	—	40	190	—	—	80	80
5	—	—	30	140	—	—	90	80
15	45	60	20	100	40	50	100	90
30	40	65	—	—	30	150	100	75
40	—	—	20	85	—	—	—	—
45	35	70	—	—	25	130	—	—
60	30	70	20	90	20	130	65	40
90	—	—	20	125	—	—	55	35
120	—	—	20	135	—	—	50	30



insulin concentrations also rose during this period from 55  $\mu$ U/ml. to 90  $\mu$ U/ml. A positive glucagon test is associated with a rise in plasma insulin of greater than 100  $\mu$ U/ml. at five minutes, an increase which may persist for as long as one hour. In addition, the blood glucose concentration frequently declines from its peak to hypoglycemic levels late after the administration of glucagon in patients with islet cell tumors.<sup>12</sup>

L-leucine (150 mg./kg., p.o.) increased plasma insulin from 50  $\mu$ U/ml. to 150  $\mu$ U/ml. in the first 30 minutes after ingestion. Blood glucose concentration gradually fell from 50 mg.% to 20 mg.% over one hour. The normal rise in plasma insulin after the ingestion of l-leucine does not exceed 28  $\mu$ U/ml. in adults unless they are receiving oral hypoglycemic agents.<sup>11</sup> Levels greater than this are considered diagnostic of an insulinoma.<sup>11</sup>

A one hour fast in our patient was associated with gradually falling glucose concentrations from 55 mg.% to 30 mg.% with a persistently elevated plasma insulin. Fasting blood sugar (FBS):insulin ratios during this period were 0.91, 0.61, and 0.46 at 0, 30, and 60 minutes, respectively. Ratios less than 2.5 reflect relative hyperinsulinism.<sup>19</sup>

## Discussion

In a general review of the sensitivity and specificity of provocative tests tolbutamide and glucagon have been associated with excessive insulin response in 70-80% of patients with islet cell tumors.<sup>20</sup> L-leucine, while positive in only 50% of these cases, has been shown to be the most specific test in adult patients. The only false positives reported have been in adult patients under treatment with oral hypoglycemic agents.<sup>23</sup> Analysis of blood glucose concentration and plasma insulin relationships during fasting has, however, proven diagnostic in the majority of cases.<sup>20</sup>

In our patient the insulin response to tolbutamide and glucagon did not fulfill the established diagnostic criterion. Moreover, the blood glucose response to tolbutamide and l-leucine although suggestive were considered to be nonspecific since they did not differ from those observed with fasting alone. During the provocative tests only the plasma insulin response to l-leucine ingestion was consistent with an insulinoma. Fasting hypoglycemia accompanied by high insulin levels produced a low FBS:insulin ratio and was also suggestive of the presence of an insulinoma.

Breidahl recommended the prolonged (72-hour) fast in diagnosis of insulinoma and reported that all his patients with hyperinsulinism were symptomatic by 53 hours of fasting.<sup>4</sup> In most normal subjects fasting does not lead to hypoglycemia and insulin levels are unchanged or decline; thus, the FBS:insulin ratio is generally greater than 2.5. FBS:insulin ratios less than this reflect inappropriate insulin levels relative to blood glucose concentration and are characteristic of islet cell adenomas.<sup>14</sup> We believe that the application of the blood sugar:insulin ratio after a 12-hour fast allows prompt resumption of feeding.

Finally, a new area of investigation may provide additional help in the diagnosis of patients with insulinoma.<sup>16,21,22</sup> Proinsulin, a precursor in the synthesis of regular insulin, usually constitutes less than 20% of the total immunoassayable insulin.<sup>21,22</sup> In many patients with insulinoma the percentage of fasting proinsulin is greater than 20% of the total insulin activity. These increased levels have not been reported in other cases of hypoglycemia. In our patient, fasting proinsulin levels were found to be 28% of total plasma immunoreactive insulin and are thus in agreement with this recent work.

## Acknowledgment

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Miami 33152.

## ...And Now They Are Gone

There are only a few people in this world that I really love,  
 Mommy and Dad, and Pammy and Sy are the ones.  
 I could always turn to them for help, love or  
     anything else I might want or need.  
 The problem is . . . Now Two are gone.  
 Pammy was always so cheerful and gay.  
 Wherever she went laughter and happiness followed.  
 Even to talk to her over the phone brought  
     something special into your voice.  
 I don't know if it was because of the way she talked or it was  
     because she's that kind of person that brings the bubbles out of you.  
 She loved her arm tickled.  
 Anytime I saw her she would stick out her arm:  
     I got the message  
 When she kissed you good-bye she had this funny  
     habit of sucking in her cheeks.  
 She sort of resembled a fish.  
 Well anyway, I loved her a lot, no, much more than a lot.  
 . . . AND NOW SHE IS GONE  
 Sy was the slow one in the family.  
 He was hardly ever on time.  
 But when he got to where he was going  
     Everyone was always glad he was there.  
 He wasn't very tall in stature  
 But as a person, he was taller than the Empire State Building.  
 He loved being with his family and friends.  
 When he was with the kids, he would lie down  
     on the floor and the little ones would walk on him!  
 I loved him a lot, too, no, much more than a lot.  
 . . . AND NOW HE IS GONE.  
 These two people were the most beautiful people in the world.  
 Their laughter, happiness, and gaiety brought  
     love into everyone's heart.  
 To know them, was to love them.  
 And, Boy, did I love them!  
 I still do!  
 It will take an awful lot to make me forget those two people,—  
 I don't think anything ever will.  
 I loved them so much . . .  
 . . . AND NOW THEY ARE GONE!

(This eulogy was written by Linda Blauner, age 13, niece of Dr. and Mrs. Seymour Shoelson. The Rabbi who delivered this eulogy, would deliver no other because of its depth and beauty.)  
 Reprinted from *The Bulletin of the Dade County Medical Association*, November 1972.

# Diabetic Hyperosmolar Nonketoacidotic Coma Complicated By Mesenteric Thrombosis

## Case Report

FREDERICK P. HOBIN, M.D. AND FRANCIS B. MARAIST, M.D.

**Abstract:** Hyperosmolar nonketoacidotic coma marked the onset of diabetes in a 63 year old male. The prognosis of this condition is poor. Hypotension, dehydration, and hemoconcentration are factors which may predispose to thrombotic complications. Despite a good response to therapy by biochemical criteria, our patient developed a fatal complication of mesenteric thrombosis with colonic gangrene. This observation leads us to believe that prompt anticoagulation of these patients may improve the outlook for survival.

The clinical onset of diabetes in older persons is sometimes manifest as hyperosmolar nonketoacidotic coma.<sup>1</sup> They have an extremely high blood glucose with polyuria and polydipsia leading to dehydration and hyperosmolality with depressed sensorium and no ketoacidosis. This syndrome develops in some of them as a consequence of infection or pancreatitis. Nevertheless, many cases without predisposing conditions have been recorded. The mechanism of death is related to hyperosmolality and hypernatremia and elimination of these conditions is the goal of therapy. However, certain serious complications may arise as a consequence of the hyperosmolality. Hypotension and acute tubular necrosis have been observed. It has also been suggested that dehydration, hemoconcentration and hypotension may predispose to intravascular coagulation to the extent that heparin might be a useful adjunct to therapy. Indeed, instances of arterial and venous thrombosis in the lower extremities have been observed. Following is a report of a case of hyperosmolality complicated by thrombosis of small

mesenteric veins with gangrene of the colon. We have not seen this particular situation reported previously.

### Case Report

The patient was a 63-year-old white male who was admitted to the hospital with chief complaint of weakness.

He gave a history of peptic ulcer dating back five years. Two weeks prior to admission he passed four black tarry stools. He was treated with a medical ulcer regimen at home because he refused hospitalization. The GI bleeding stopped but increased thirst and polyuria developed. He lost seven pounds and became progressively weaker. The remaining history was noncontributory.

Physical examination on admission revealed a well-developed, well-nourished male who was conscious but stuporous. His temperature was 96 F. and blood pressure 136/80. He had a rapid regular pulse of 148/min. and a respiratory rate of 48/min. The remainder of the physical examination was within normal limits.

Initial laboratory data: hemoglobin 14.8 Gm., hematocrit 43%, WBC 14,000 with 81% segmented neutrophils, 12% band neutrophils, 5% lymphocytes, and 2% monocytes. Urine specific gravity was 1.032, and there was 4+ glycosuria. Tests for blood, acetone and albumin were negative as was microscopic examination of the urine. Fasting blood sugar was 1,750 mg. %. BUN was 99 mg. %, and serum acetone was negative on repeated examination. Sodium was 150 mEq./L., potassium 2.6 mEq./L., chloride 124 mEq./L., and CO<sub>2</sub> content 17 mEq./L. Serum amylase was 230 units. An SMA-12 biochemical profile revealed no additional abnormalities except for borderline elevation of uric acid. Admission chest x-ray was normal. EKG showed supraventricular tachycardia. Initial treatment during the first 12 hours included administration of regular insulin, 300 units IV and 150 units SC, and 2,000 ml. of 0.45% NaCl with 40 mEq. KCl added IV. Repeated blood sugar determinations during this period showed reductions to 1,014, 790, 510, and then 72 mg. %. BUN fell slightly to 82 and repeated serum electrolytes were sodium 157 mEq./L., potassium, 4.1 mEq./L., chloride 131 mEq./L., and CO<sub>2</sub> content 16 mEq./L.

However, at this time progressive abdominal distention and cyanosis of the lower extremities developed rapidly. The blood pressure fell to 102/80. Abdominal x-rays showed findings of a paralytic ileus. He was taken to surgery with a presumptive diagnosis of mesenteric thrombosis.

At surgery he was found to have grayish to blue-black discoloration of the colon from the cecum to the rectosigmoid junction. Colonic arterial pulses were not palpable. In an effort to save the patient's life an ileocelectomy was carried out, including a resection of the distal 10 cm. of ileum. Unfortunately, the patient expired before the surgical procedure could be completed.



Microscopic examination of the ileocectomy specimen revealed hyperemia and edema of the small intestinal portion. There was gangrene of the entire colon which ceased abruptly at the distal rectosigmoid level. Thrombus was found occluding one of the small colonic veins. There was further opportunity to examine the remaining mesenteric arteries and veins at autopsy and these vessels were patent. Other abnormalities noted were mild generalized atherosclerosis, penetrating duodenal ulcer, and early nutritional cirrhosis of the liver.

### Discussion

Normal serum osmolality is in the range of 270-295 mOsm/L.<sup>2</sup> Patients with the hyperosmolality syndrome tend to have serum levels of about 350.<sup>3</sup> Calculated osmolality by the method of Warhol et al.<sup>2</sup> for our patient was an extremely high 439. The hyponatremia provided additional evidence of dehydration. The hyperpnea was attributed to lactic acidosis. It seems possible to exclude mesenteric venous thrombosis as the precipitating cause of this diabetic crisis for three reasons. The duodenal ulcer was the most probable cause of the melena two weeks prior to admission. Polyuria and polydipsia developed over the intervening two weeks culminating in the patient's stuporous condition. Finally, the patient had no signs or symptoms referable to the gastrointestinal tract on admission. Abdominal distention and ileus developed only after the hyperosmolality had reached its full extent.

The prognosis of patients with hyperosmolality due to diabetes is poor, with overall survival estimated at 50%.<sup>1</sup> Prevention of thrombotic complications seems a worthwhile goal in attempt-

ing to improve the chances of survival. The occurrence of mesenteric thrombosis furthermore suggests that intravascular clotting does occur and is independent of local vascular factors which might have been implicated in those cases where the clotting occurred in the lower extremities.

In view of the recorded clinical experience to date, we would consider a patient with hyperosmolar coma to be a candidate for heparin anticoagulation, especially if there is hypotension, severe atherosclerosis, varices, or other local factors which might predispose to thrombosis.

### Summary

A 63-year-old white male had the clinical onset of diabetes mellitus manifest by hyperosmolar nonketoacidotic coma. Despite good response to medical therapy by biochemical criteria, mesenteric vascular insufficiency developed with gangrene of the colon. Thrombotic phenomena may be a complication of hyperosmolality, and perhaps anticoagulation may be a useful adjunct to the therapy of patients with this condition.

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After 16 months of deliberation marred with dissension, a federal advisory commission has decided not to recommend any single solution to the problem of medical malpractice insurance. The gist of the divided commission's report to HEW is to explore a variety of ways to modify malpractice laws at the state level.

# Amniotic Fluid and Fetal Maturity

QUDRATULLAH MOJADIDI, M.D.

**Abstract:** This study of 57 amniocenteses performed upon 49 patients in a 12 month period showed the procedure to be safe and analysis of the amniotic fluid useful in the determination of gestational age, and confirmed that a creatinine concentration of 1.5 mg.%, optical density for bilirubin of 0.05 at 450 m/<sup>m</sup> and 10% or more orange cells correlate with a gestational age of 36 weeks or more and a fetal weight of 5 pounds 8 ounces or more. The creatinine concentration is most reliable in determining gestational age among Rh negative sensitized mothers with Rh positive fetuses.

Estimation of fetal maturity is a problem not infrequently encountered by the obstetrician. Radiographic findings for this purpose have been most popular but they are not always accurate. Analysis of the amniotic fluid direct from the fetal environment holds considerable promise in substantiating fetal maturity. This method has not been widely utilized; it had to await the accumulation of sufficient evidence demonstrating the safety of amniocentesis. Now, complications associated with the procedure are being found infrequently.

In the Department of Obstetrics and Gynecology at University Hospital of Jacksonville, we are gaining experience with analysis of the amniotic fluid in spectrophotometric determination of bile pigment, cytology of fetal desquamated cells and determination of creatinine concentration as these relate to the maturing fetus.

## Materials and Methods

Between July 1969 and June 1970, we performed 58 amniocenteses upon 49 patients. Of the specimens, 53 were analyzed for both creatinine and bilirubin and, in addition, 15 were examined cytologically. Among these patients determination of fetal maturity was indicated due to repeat

cesarean section, diabetes, toxemia and possible Rh incompatibility problems. Findings were correlated with gestational age by history and birth weight. The majority of the patients were delivered within three days of the last amniocentesis; none were delivered later than six days.

Prior to the procedure the patient is examined to determine fetal position and to identify the small parts. Then with the skin anesthetized, a 22 gauge needle with stylet is directed at the small parts, 10 cc. of fluid is aspirated and placed in two tubes. Protected from light as much as possible, the specimen is sent directly to the laboratory and a slide prepared with one drop. Cells are stained with Nile blue sulfate. After slight heating, a cover slip is placed over the material and 200 cells counted; thereby determining the percentage of orange cells. A Beckmann spectrophotometer is used to determine amniotic fluid bilirubin. The Jaffe reaction measures the amount of creatinine.

## Results

This study confirmed that the concentration of creatinine in amniotic fluid increases with gestational age. In 93% of cases or 46 patients a creatinine level of 1.5 mg.% or more correlated well with a birth weight of 5 pounds 8 ounces or more and 36 weeks or more gestational age. For the remaining three patients the birth weights were 4 pounds 12 ounces in one and 5 pounds 6 ounces for the other two (Figs. 1, 2).

Bilirubin as measured by optical density of amniotic fluid at 450 m/<sup>m</sup> was found to be reliable in 93% of cases. A density of 0.05 or lower correlated well with gestational age of 36 weeks or later and birth weight of 5 pounds 8 ounces or more (Figs. 3, 4). Optical density gradually approached zero as pregnancy progressed.

Among the group cytologically examined, patients with 10% or more orange staining cells were more than 36 weeks gestational age and more than 5 pounds 8 ounces birth weight (Figs. 5, 6).

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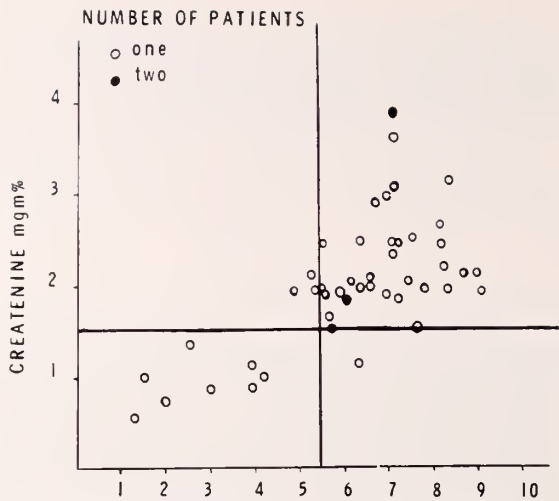


Fig. 1.—Birth Weight. Amniotic fluid creatinine in mg.% and birth weight.

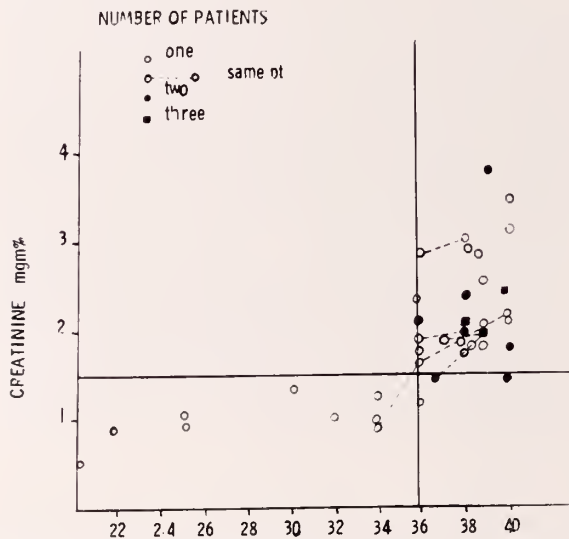


Fig. 2.—Weeks of Gestation. Amniotic fluid creatinine in mg.% and various gestational ages.

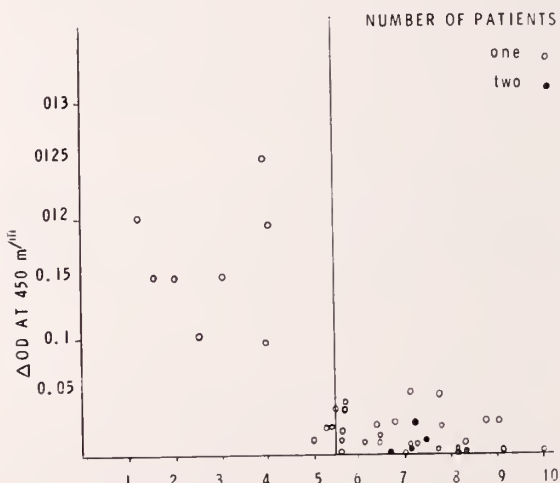


Fig. 3.—Birth Weight in Pounds. Amniotic fluid bilirubin measured by spectrophotometry and birth weight.

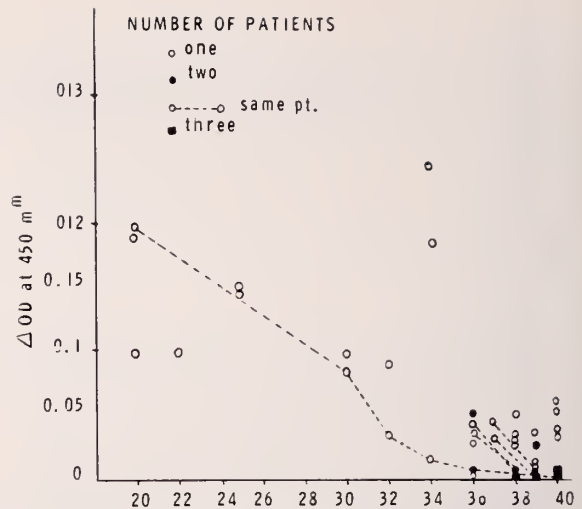


Fig. 4.—Weeks of Gestation. Amniotic fluid bilirubin measured by spectrophotometry at 450 m<sup>u</sup> in various gestational ages.

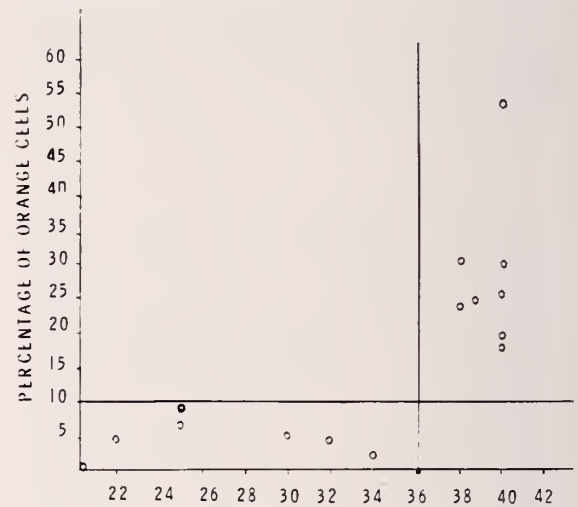


Fig. 5.—Weeks of Gestation. Percentage of orange staining cells in various gestational ages.

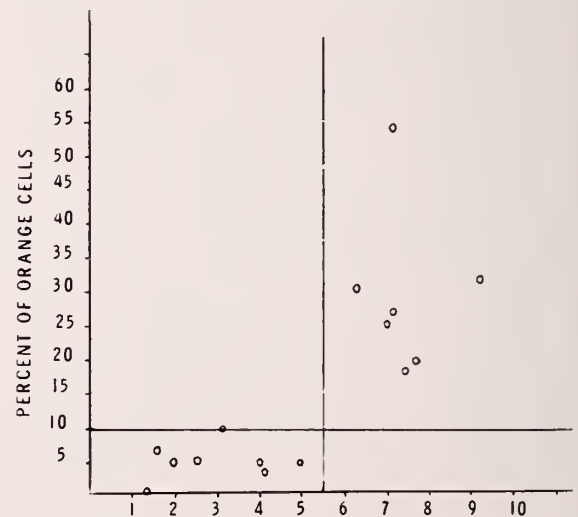


Fig. 6.—Birth Weight. Percentage of orange staining cells and birth weight.



## Comment

Methods used for estimation of fetal maturity include radiographic findings of the fetus;<sup>1</sup> ultrasonic determination of fetal biparietal diameter;<sup>2-4</sup> amniotic fluid osmolality;<sup>5</sup> study of amniotic fluid desquamated cells, creatinine concentration and spectrophotometric analysis of bile pigment.<sup>6-12</sup>

A significant correlation has been found between the amount of bilirubin determined by the optical density of the amniotic fluid and gestational age. Maturation of the conjugating enzyme system of the fetal liver is thought to account for this phenomenon. The route of bilirubin entry into the amniotic fluid is not precisely known. It may be through the umbilical cord and placental vessel (Fig. 7).

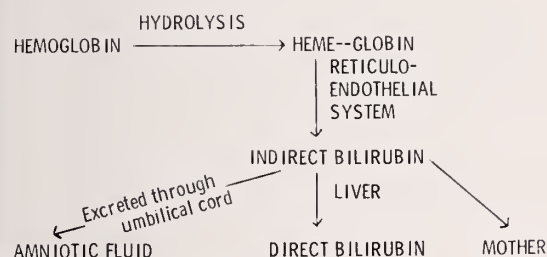


Fig. 7.—Bilirubin Metabolism.

In the Rh negative sensitized mother with Rh positive infant, the correlation between amniotic fluid bilirubin and gestational age has not been found reliable. Creatinine concentration, however, is useful in determining fetal maturity.

The correlation between gestational age and creatinine concentration in amniotic fluid was first reported by Pitkins and Swirek in 1967.<sup>13</sup> It had been shown previously that the concentration of organic nitrogen compounds such as uric acid, urea and creatinine was the same in amniotic fluid, maternal and fetal serum early in pregnancy.<sup>14,15</sup> Creatinine rises very slowly up to 34 weeks gestation, then an abrupt increase occurs.<sup>16</sup> After 37 weeks the concentration is two to three times the normal level in serum. Maturation of the fetal renal and liver functions and increasing body muscular mass are thought to be responsible for the increase.

Metabolism of creatinine is outlined in Figure 8. Kidney, liver and muscle are major organs participating.

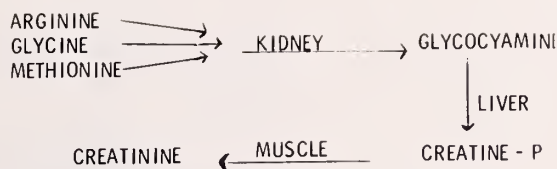


Fig. 8.—Creatinine Metabolism.

A variety of cytologic changes have been observed in amniotic fluid cells after the 38th week. There is a higher percentage of anucleated, polygonal and orange staining cells.<sup>9</sup> Near term the percentage of orange staining cells dramatically increases. Brosens and Gordon<sup>17,18</sup> suggested that these cells originated in the fetal sebaceous glands.

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# What it means to live and work in Tipton County, Tennessee

**Persons who are white and  
over 40 have one chance in four  
of having solar keratoses...  
which may be premalignant**

An epidemiologic study\* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons  
over 40 in Tipton County, Tennessee**

Female	159	44
Male	117	66

☐ Persons without solar keratoses    ☒ Persons with solar keratoses

\*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.





## **solar, actinic, senile keratoses**

called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

## **Sequence/selectivity of response**

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)\* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

## **Cosmetic results**

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

## **5% cream—a Roche exclusive**

Only Roche formulates the 5% cream... high in patient acceptability... high in clinical efficacy, especially for lesions of hands and forearms... economical.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

# **an alternative to conventional therapy**

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## **(fluorouracil) cream/solution**



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# Copernicus Remembered

I. LEO FISHBEIN, M.D.

On February 19, 1973 the world commemorates the birthday of Nicolaus Copernicus, born 500 years ago into the family of Niklas Koppernigk, a St. Dominic Catholic copper dealer in a small town on the Vistula River in northwest Poland. The father died in 1483 and the children, Barbara, Katherine, Nicolaus and brother, Andrea, who died of leprosy in 1519, were adopted by the maternal uncle, Lucas Watzenrode, who later became Bishop of Ermeland.

Copernicus spent his early years at St. Anne's Alley and attended school at St. John's Church in Torun. In 1492 he began the study of mathematics at Crakow University, spending three years in the Faculty of Arts, then enrolled in the School of Law at Bologna where he met Domenico da Navara, professor of astronomy.

In 1497 his uncle, the Bishop, made him Canon of Frauenburg Cathedral and in 1500, the Jubilee Year, he taught mathematics in Rome. The next year he studied Greek at Padua and in 1503 obtained a Doctorate in Canon Law at Ferrara. He also studied medicine at Padua and became deeply interested in the writing of Galen and Avicenna. For the next six years he was medical advisor to his uncle at Heilsberg and practitioner among the poor.

At age 27 he concluded that science and truth were his future and in Allenstein he studied the earth, moon and stars, "the bright assemblies of the skies," with crude wooden instruments. He Latinized his name, which had been the same as his father's, and became known throughout the region as a churchman, statesman, physician, judge, astronomer, inventor, economist, poet, soldier and research scientist. His treatise in 1526, "De Monetariae Cudendae Ratione," written by order of King Sigismund I, proposed to reform the currency of the Prussian provinces of Poland.

He was a faithful diocese administrator, geographer, assessor, mapmaker, ambassador, classicist philosopher and commander-in-chief of the defense of Allenstein Castle when the Teutonic Knights headed by Albert Hohenzollern besieged

it. The plague failed to spread to the castle because he discovered that bread became contaminated on touching the ground and ordered that the loaves be covered with light cream to detect soil contact.

Copernicus worked at Frauenburg Cathedral for 30 years and this lifetime of research and inquiry produced "De Revolutionibus Orbium Coelestium" (The Revolution of Heavenly Bodies) which he dedicated to Pope Paul III. George Joachim Rheticus, a pupil and professor of mathematics at Wittenberg, persuaded him to publish the original manuscript at Nuremberg. No new knowledge of the heavens had been advanced since 150 A.D.

In 150 A.D. Claudius Ptolemaeus of Alexandria had tabulated more than 1,022 stars visible to the eye and predicted future eclipses of the sun and moon. He adopted from Hipparchus the division of the equatorial circle into 360 parts (degrees) and meridians with latitudes and longitudes. His geocentric system, "The Mathematical Collection," almagest, would not be surpassed



Nicolaus Copernicus

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for 1400 years when Copernicus presented the more modern heliocentric system. Copernicus used the tools of Ptolemy's period but his great mind evolved newer and more realistic revolutionary storms. He "stopped the sun and set the earth in motion;" it became a planet and the sun became a star.

Andreas Osiander, a pupil of Copernicus, secretly prefaced the manuscript and reminded readers that the ideas presented were only theories and not meant in any sinister manner to overthrow the power and glory of God in the Heavens.

Copernicus summed up the research:

In the Middle of all, it's the Sun, enthroned. In this most beautiful temple, could we place this luminary in any better position from which he can illuminate the whole at once? He is rightly called the Lamp, the Mind, the Ruler of the Universe. Hermes Trismegistus names him the "Visible God"; Sophocles' Electra calls him the "All-Seeing." So the Sun sits as on a royal throne ruling his children and the planets which circle round him . . . That which pleases the people I do not understand; that which I understand does not please them. We stand apart. The true enigma of the world is the concern of a dozen men. The billions of men live like children. A glance at the stars, four thousand or four hundred years ago—that is the beginning and the end of wisdom. What is there more beautiful than the heavens which, indeed, comprise all beauty?

His dedication to Pope Paul III was partly a humble apology and sincere request for reason and compassion in viewing the manuscript:

I can easily conceive, most Holy Father, that as some people learn that in this book which I have written concerning the revolutions of the heavenly bodies, I ascribe certain motions to the Earth, they will cry out at once that I and my theory should be rejected. This book had lain in my study not nine years merely, but already going on four times nine. I found first, indeed, in Cicero, that Niceta perceives that the Earth moved; and afterward, in Plutarch, I found that some others were of this opinion, whose words I have seen fit to quote here, that they be accessible to all.

Some maintain that the Earth is stationary; but Philolaus, the Pythagorean, says that it revolves in a circle about the fire of the ecliptic, like the sun and the moon. Heraklides of Pontus, and Ekphantus, the Pythagorean, make the Earth move, not changing its position, however confined in its falling and rising around its own center in the manner of a wheel. I describe in the first book all the positions of the orbits together with the movements which ascribe to the Earth, in order that this book might contain, as it were, the general scheme of the universe. In order, however, that both the learned and unlearned equally may see that I do not avoid anyone's judgment, I have preferred to dedicate these lucubrations of mine to Your Holiness rather than to any other; because, even in this remote corner of the world where I live, you are considered to be the most eminent man in dignity of rank and in love of all learning, and even of mathematics; so that by your authority and judgment you can easily suppress the bites of slanderers, albeit the proverb hath it that there is no remedy for the bite of a sycophant. It is not unknown that Lactantius, otherwise a female writer but a poor mathematician, speaks most childishly of the shape of the Earth when he makes fun of these who said that the Earth has the form of a sphere. It should not seem strange then to zealous students, if some people shall ridicule us also. But what I may have accomplished herein I leave to the judgment of Your Holiness in particular, and to that of all other

learned mathematicians; and lest I seem to Your Holiness to promise more regarding the usefulness of the work than I can perform, I now pass to the work itself.

Copernicus believed that the air surrounded the earth as it moved in its circuit; that the stars moved in orbits, some nearer than others and some remote in the firmament; that the revolution of the earth on its axis had to do with the diurnal rotation of the heavens. The myth of the "fixed earth" exploded with a gigantic blast that shook complaisant man's world. No longer would he continue to believe the Ptolemaic doctrine that the earth stood still while the heavenly bodies moved around it. For 15 centuries that had been accepted as truth. Ptolemy had held that the stars were stuck on the surface of a sphere. Pythagoras and other Greek scholars, in 500 B.C., had stated that the sun was the center of the universe, without substantial proof.

Copernicus' book began a renaissance in astronomical design. He had tolerated man's folly and ignorance for a lifetime and now as "king of the humanists" demanded that the truth be heard. He was a revolutionary, a visionary, and the Church feared his science.

Oligarchies ruled in the known world and despots had power of life and death. Atheists were burned at the stake; heretics paid the price of injustice, misery and gaol. The Church eliminated disbelievers and Copernicus always had feared he would be burned alive for his heretical pronouncements. He had called the sun "the soul, the light of the world, placed on a royal throne in the center of the universe where it guided the family of stars circling around it."

He had moved the earth centrifugally into the vast realms of space, but completed his life as the "divine truth-seeker." In 1543 at 70 years of age while his truths cast their luminescence electrifying men's minds, the scientist-saint-sage was dying of a stroke and paralysis with the first copy of his masterpiece in his hands. His golden mind left a treasure for man to ponder for generations and his star would shine forever in the heritage of "Per Aspera, Ad Astra!"

At Crakow University there is a monument to him with the inscription: "Sta Sol, ne Moveare!" (Sun, Stand Still, Move Not!). There is another statue in the Frauenberg Cathedral: "Astronomo celeberrimo cujus nomen et gloria utrumque implevit orbem" (To the celebrated astronomer whose name and glory have completed the world).

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# The Weed System

## An Innovative Approach Toward Better Medical Records

ARVEY I. ROGERS, M.D.

**Abstract:** Dr. Lawrence Weed recognizes five basic components of the medical record: data base, problem list, initial plans and formulation, progress note and discharge note, and proposes to interrelate them through an orientation common to the patient's problems. This innovative problem-oriented systematic approach to medical record maintenance deserves the attention of health professionals who recognize deficiencies in our current medical record "non-system." Long-term advantages would appear to outweigh short-term practical disadvantages. Major obstacles to introducing the system anywhere appear to be related to resistance to innovation, difficulties with the system's mechanics, and creation of a faulty problem list. Each of these can be overcome when an organized approach involving committed leadership operates.

The problem-oriented medical record offers promises and creates problems.<sup>3</sup> It promises to be a better way of maintaining a medical record. It creates the problems related to change. It appears that the innovative approach to medical record maintenance developed and popularized by Dr. Lawrence Weed or some modification of it will be adopted by medical schools in an effort to teach a standard approach to recording information related to the patient and his problems. It is an inevitability that medical records of the future will be increasingly problem-oriented.

Whether the physician chooses to introduce this new system into his practice is a personal matter. It is dictated solely by considerations of convenience and quality of care delivered his patients. While not proven, it is likely that both would be enhanced. The elements of the problem-oriented medical record should be known and the system at least tried before an intelligent decision is made regarding its applicability to a given physician's practice. This article is written to

discuss Dr. Lawrence Weed's problem-oriented medical record.<sup>1,2</sup>

### Essential Elements of Record

The basic premise is that all elements of the medical record are interrelated by a common orientation to the patient's problems. These problems are identified by the physician or other professionals trained to compose the problem list. This list is derived from the history,\* physical examination and initial laboratory data; when compiled, this information is known as the data base. Initial plans detail just how the physician intends to further diagnose and treat the patient as well as educate him regarding his disease process; this is done for each problem which the physician intends to follow throughout the patient's hospitalization. Progress notes are problem oriented, including information presented in an organized manner to reflect progress in a specific problem area. Thus, you have the four essential elements of the problem-oriented medical record: I. Data Base, II. Problem List, III. Initial Plans and IV. Progress Notes.

I. DATA BASE.—The information comprising the data base is critical; from it the problem list is derived and on it all subsequent evaluation is based. Considerable skill is required to obtain historical and physical data. Evaluation of prior records is an essential part of this data base as is a listing of medications currently being prescribed for the patient. Careful review of old records is too infrequently undertaken. No record should be thought of as "an old record" when a patient is admitted to the hospital or seen for the first time in an ambulatory setting. The record should reflect the patient's medical and surgical illnesses. Another element of the data base which should be included is a profile of the patient. (i.e., a description of the patient, how he spends his day, etc.). Some laboratory data may already be available and some may be obtained stat and will include examination of biological fluids, x-rays, electrocardiograms, etc.

\*Inclusive of old records, reductions, lab tests, x-rays, etc.

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II. **PROBLEM LIST.**—This is just what it says, a problem list. The patient's problems as determined by the data base are numbered and listed on the front of the chart and designated in separate columns as active or resolved. An active problem may become assimilated into other problems or resolved during a hospitalization or office follow-up. This portion of the medical record is the most important and the most difficult to obtain properly. A problem is something determined to be wrong with the patient. It may range from an etiologic diagnosis to an abnormal laboratory test.

You can only list that which is justified from the data base, i.e., a problem is never a question, only a fact. A problem could read as follows in a patient who presents with dyspnea:

1. Arteriosclerotic heart disease with decompensated congestive heart failure or
1. Congestive heart failure unknown etiology or
1. Dyspnea or
1. Abnormal electrocardiogram.

Which of these occurs will vary with the accuracy and completeness of the data base as well as with the degree to which synthetic skills have been developed in the individual responsible for the final problem list. For example, the individual who fails to determine that the individual presenting with dyspnea of effort also has paroxysmal nocturnal dyspnea, two-pillow orthopnea, angina, a past history of a documented myocardial infarction and a diastolic gallop with inspiratory rales at both lung bases will be unable to diagnose congestive heart failure on an arteriosclerotic basis. He may be able only to list dyspnea or an abnormal electrocardiogram. And furthermore, even if he does elicit this relevant information but doesn't know its significance, he will still be left with listing dyspnea or an abnormal electrocardiogram. Of most importance is that the elements in the data base are accurate and that the most skilled individual caring for the patient be responsible for comprising the ultimate problem list. The revised problem list may only be completed after 72 hours in the hospital when critical data is obtained.

A short problem list follows:

ACTIVE		RESOLVED
1. Chest pain	11/15/71	11/18/71
2. Dyspnea	11/15/71	11/18/71
3. Abnormal electrocardiogram	11/15/71	11/18/71
4. Diabetes	1964	
5. Obesity		
6.		
7.		
8. Acute myocardial infarction with mild congestive heart failure	11/18/71	Appendectomy, 1945 Cholecystectomy, 1961
(formerly problems 1-3)		

III. **INITIAL PLANS.**—This section is basically the first progress note and consists of the following sections:

A. **Diagnosis.** Listed here is what you intend to do in order to establish a definitive diagnosis of the patient's problem as well as to rule out differential diagnostic possibilities. These should be listed in as much descriptive detail as possible (i.e., "serial enzymes" is less satisfactory than "SGOT, LDH, HBD AND CPK daily X5 days" when attempting to document a recent myocardial infarction).

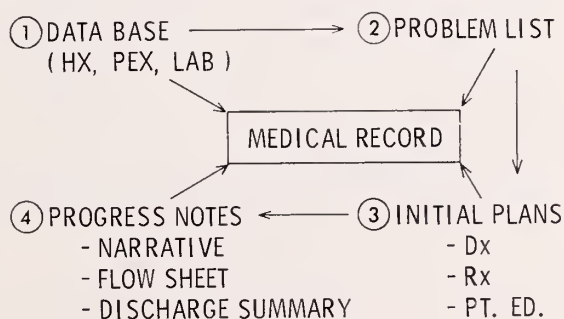
B. **Therapy.** Listed here is what you intend to do in order to treat the problem which you have determined to be treatable in a specific or nonspecific way. Again, detail is desirable.

C. **Patient Education.** This should be included as deemed appropriate to a specific problem. It is too often a neglected part of patient evaluation. We are no longer mystics; effective communication is essential to optimal patient care.

The initial plans section is written for each problem to be followed during the current hospitalization. These should be numbered and titled so as to correspond to the problem list.

IV. **PROGRESS NOTES.**—Three varieties of progress notes can be identified in a medical record. They are: Narrative Note, Flow Sheet, and Discharge Note. Each deserves separate comment.

A. **Narrative Note.** This is the most frequent variety of progress note found in medical records.



We refer to this note when attempting to determine a patient's progress; from it, we often obtain useless information and cannot satisfactorily determine progress. There is no reason for this, especially if the notes are problem-oriented.

Each narrative progress note is numbered and titled to correspond to the numbers and titles in the problem list. One or several might be written on any given day. If there is no progress, none is written.

Each progress note contains four parts: Subjective; Objective; Assessment, and Plan. These are self-explanatory and require no further discussion. They may be abbreviated as s, o, a and p. No pun is intended, but this type of note really cleans up a medical record.

B. Flow Sheet. A patient admitted acutely ill with cardiogenic shock, supraventricular tachycardia, diabetic ketoacidosis or other acute emergencies cannot be followed appropriately with a narrative note. The standard flow sheet designed so as to contain elements to be followed and recorded at timed intervals should be utilized and follow a numbered, titled problem.

C. Discharge Note. This is really the ultimate narrative progress note. It is, in essence, the discharge summary as well. Each problem should be numbered and titled as in the medical record. The information to follow each problem should include subjective, objective, assessment, plan for followup, medications, etc. (See editorial, page 42).

## Advantages of System

It is not easy to make the change to this new medical record maintenance system but probably worth the effort when one reviews the advantages it offers. As discussed by Dr. Willis Hurst, they are:<sup>4</sup> 1. Encourages use of sound logic in thoughts about patients; 2. Efficient record utilization; 3. Enhances communication to other health professionals concerned with patient care; 4. Enhances physician continuing education; 5. Prepares personnel for the computer age; 6. Common bond between several doctors and a patient-group practice; 7. Makes possible accurate clinical research; 8. Should lead to elimination of lectures on rounds; 9. Should eliminate presentation of irrelevant data and enhance development of logic, and 10. Improve patient care.

I believe practitioners should try the Weed System, if for no reason other than to know why they do or do not like it. Try it. It promises to make your medical records better than they are now.<sup>4</sup>

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► Dr. Rogers, 1201 Northwest 16th Street, Miami 33125.

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The director of the FDA's Bureau of Drugs has charged before a Senate subcommittee that physicians are over-prescribing antibiotics, resulting in an increased number of "resistant strains of bacteria and an increased number of superinfections."

"There may be 100,000-300,000 cases each year of blood poisoning from superinfections, of which 30 to 50 per cent are fatal," according to testimony before the Senate Small Business' Subcommittee on Monopoly by Henry E. Simmons, M.D.

Harry F. Dowling, M.D., Emeritus Professor of Medicine, University of Illinois, said "it is doubtful the average person has an illness that requires treatment with an antibiotic more often than once every five or ten years." Antibiotic production has needlessly increased, however, in the past ten years, he said.

The physician's fear of failure to help his patients—stronger than his fear of complications—motivates him to prescribe antibiotics, suggested Calvin M. Kunin, M.D., of the University of Wisconsin School of Medicine.

# The Role of the County Medical Society in the Community Drug Abuse Problem

DAVID J. LEHMAN, M.D.

**Abstract:** With the use of dangerous drugs and substances of epidemic proportions in urban America, it has become increasingly important to attempt to delineate the role of the practicing physician and the county medical society. Some reasons for non-involvement by some physicians are given. The importance of placing a placard within physicians' offices to open lines of communication is discussed. The CODAC program of the Maricopa County Medical Society in Arizona is outlined as a possible basis for Florida county medical societies to attack the problems. The Committee on Drug Abuse of the Florida Medical Association is anxious to help and cooperate with any medical society desiring its assistance.

Estimates of percentage of drug usage by high school children in urban areas throughout America vary widely. There is little doubt, however, in perusing the medical literature that the degree of drug usage is approaching epidemic proportions. It is also well known that most young people obtain their drugs at school or at neighboring stores or restaurants near the schools. The use of dangerous drugs and/or substances has extended into the elementary schools. Marijuana is usually the drug selected to "turn on" initially, and thereby enter the drug scene. The use of adulterants such as PCP, strychnine, arsenic, talc and quinine have added further dangers to the use of these drugs. It is also well known that more and more young people are experimenting with heroin.

The vast majority of youthful drug users come from middle class families both black and white without any major domestic problems. Why such a high percentage of drug use by our children? We use the letters in the word "APE" as a possi-

ble answer—A for availability, P for peer pressure and E for experimentation. Drug abuse is primarily a medical problem associated with important psychological and social factors. It is, therefore, essential that physicians become involved if there is to be any chance of controlling the drug abuse epidemic that is sweeping our nation today. The literature appears to indicate that the most successful programs in operation are those in which a local county medical society has been the organizing force behind a meaningful community drug dependency program.

Relatively few physicians have become actively involved, possibly because of one or more of the following reasons:

Lack of knowledge about the nature and extent of the drug abuse problem.

Because of bad experiences in treating drug abusers within their own practices.

Rumors of bad experiences in the treatment of drug abusers by their colleagues.

The difficulties encountered in persuading the drug abuser to follow therapeutic regimes.

The uncomfortable feeling of not knowing how to manage a drug abuser.

The feeling of some physicians that neither their own families nor their patients could possibly be involved with drugs.

The failure of some physicians to communicate due to their prejudiced feelings against the unkempt children with long hair, fearing that some regular patients might be frightened away from their offices.

The fear that if they begin treating "druggies" that they will be faced with the possible theft of narcotics, needles and syringes and prescription blanks.

The frustration felt by many physicians because of the lack of community resources so desperately needed to treat drug-dependent children.

## County Medical Society Programs

More and more physicians are finding to their dismay that their own children are using danger-

Dr. Lehman is chairman of the Subcommittee on Physicians' Community Involvement, member of the Committee on Drug Abuse of the Florida Medical Association.



ous drugs. When faced with this crisis, many of them volunteer to assist in one or more community programs. They are needed to treat overdose cases, advise families concerning their children who are experimenting with drugs, assist with prevention and treatment programs within industry and business, and to work with the local educational system in planning effective prevention programs.

The Board of Governors of the Florida Medical Association has approved the printing of a placard to be placed on a voluntary basis in the offices of physicians who treat families. It reads: "To My Patients: Many young people are using dangerous drugs in our community. If you think that you have a problem in your home, please do not hesitate to discuss it with me. I want to help." It is hoped that more parents will talk about a drug problem with their doctor. Then the physician will be in a position to make a meaningful referral and possibly alleviate tension within the home. Psychiatric counseling can be requested if indicated.

Many of us working in this field feel that the use of methadone in children should be limited to the treatment of acute withdrawal symptoms or chronic long-term addiction. We do not condone the use of methadone maintenance in young, short-term users. Most children who have not been on heroin for long periods of time need no methadone in order to "kick the habit." It has also been recommended by the Board of Governors that physicians drastically reduce prescriptions for amphetamines.

The CODAC program of the Maricopa County Medical Society in Arizona illustrates dramatically how a county medical society can be the hub of an entire community drug dependency program. The programs have eliminated the unnecessary duplication of effort of many community agencies competing against each other for money and community support. There has been excellent cooperation from all segments of the

community, clergy, law enforcement, lawyers and elected officials.

The primary responsibility of the coordinating council is to provide continuity of care on a community-wide basis. Some of the programs receive funds, others are nonfunded such as those operated by the community hospitals. The seven agencies that depend upon CODAC for funding are:

1. Methadone maintenance programs.
2. A 24-hour emergency service for young people experiencing bad trips, overdoses or just wanting to talk with someone who has been through the drug scene. The staff consists of former drug addicts plus physicians and nurses on a volunteer basis.
3. An outpatient treatment center to provide needed treatment for recovering drug abusers. Group and individual therapy sessions are conducted by a psychiatrist and several ex-drug users.
4. Group discussions for parents and drug-dependent children held weekly.
5. A long-term rehabilitation center for hard-core addicts.
6. Teen involvement which serves as the educational arm of CODAC: (a) Attempt to get children, 3rd through 8th grade, to identify with a peer group not involved with drugs; (b) Community planning.
7. Comprehensive planning for overall long-range attack on drug abuse.

CODAC has been funded by the National Institute of Mental Health for inpatient services, outpatient services, emergency service, intermediate services, education and consultation, and rehabilitation.

It seems clear to us that many of the larger county medical societies in Florida through their drug committees may be able to spearhead similar programs. The members of the Committee on Drug Abuse of the Florida Medical Association hope that new meaningful programs to combat the community drug dependency problem will be forthcoming in the near future under the leadership of the county medical societies. We will be glad to cooperate and assist any society that requests our help.

► Dr. Lehman, 2740 Hollywood Boulevard, Hollywood 33020.

#### Organization of CODAC

##### Financial Services

- a. Finance
- b. Budget
- c. Resources and development

##### Professional Services

- a. Education and prevention
- b. Treatment and rehabilitation
- c. Training and research

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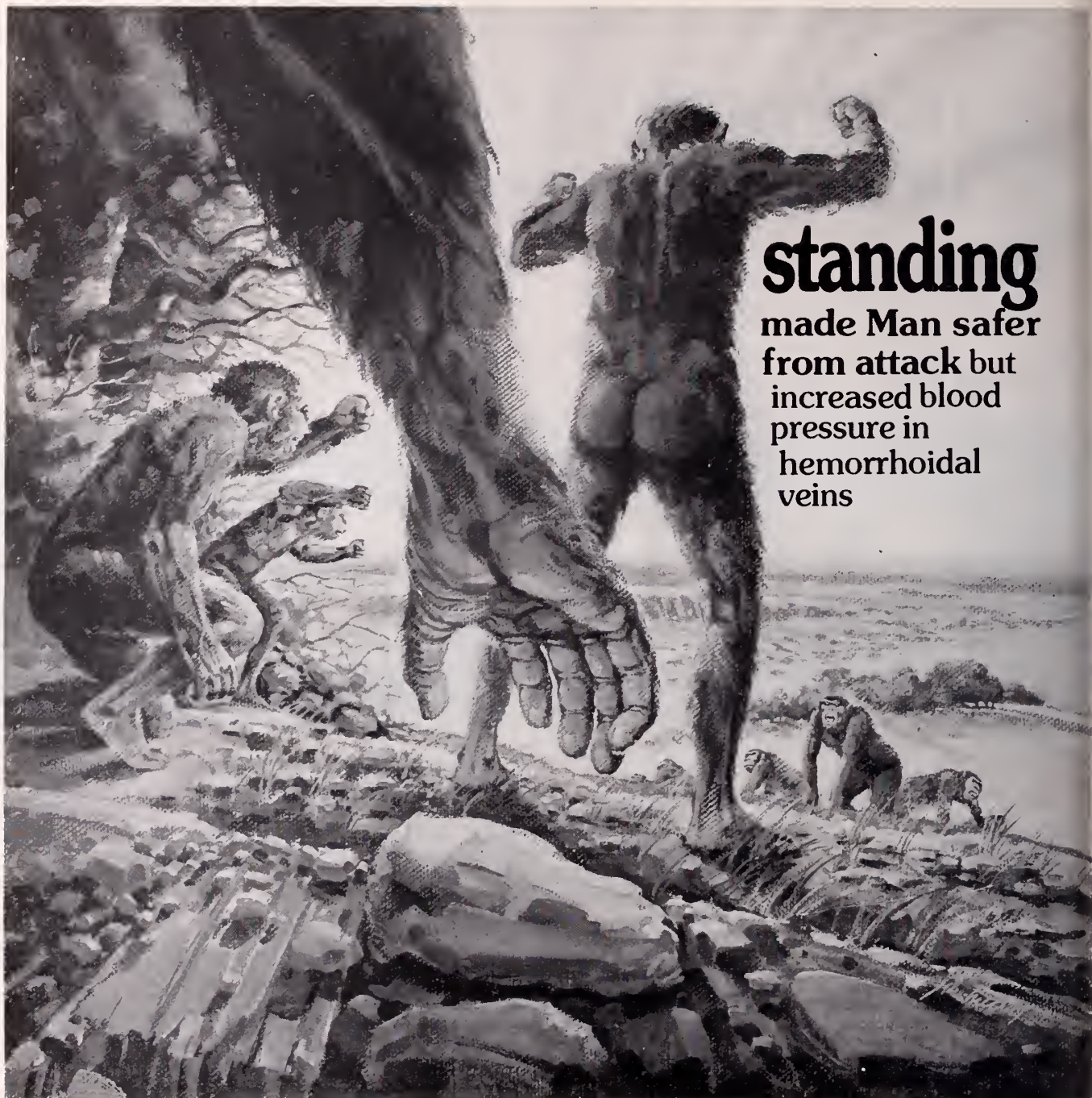
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## Editorials

### Continuing Medical Education

In 1967, the Oregon Medical Association passed a resolution requiring participation in a continuing education program as a prerequisite for membership with a deadline of December 31, 1971. Since then, eleven members were suspended for failure to meet the requirements and eight others have resigned, resulting in a loss of 19 members but more than offset by the 176 new members who joined the society, suggesting that the proposal has not been detrimental to membership recruitment or retention. With some 2,000 members, the OMA resolved difficulties in setting standards by deciding that representatives of specialty groups in the state determine the requirements for members in each discipline. All members are required to participate except those in training. Personal exemptions may be taken into consideration but usually substitution is offered rather than exemption. An appeal mechanism is available. Legal problems have yet to be encountered and the rank and file of the society are satisfied with the philosophy behind the recertification program. To implement this the state association fashioned a program of continuing medical education, hospital-based and locally run to meet the educational and attitudinal needs of the practicing physician.

One excellent method of continuing education of physicians is the utilization of peer review. Not a new concept, this initially was set up to meet the demands of the public for lowering the cost of medical care but has now grown into concern for high quality care for all patients. Called "Medical Care Evaluation," it is a free consultation with one's peers and should give one no need to fear unless one is hiding shady procedures or is woefully out of date in keeping up. As the concept matured, the reviewing physician needed standards, for evaluation of quality care consists of a dual process, prior establishment of standards and the measurement of actual performance against those standards. For whenever professional standards in performance appear to serve the interest of a profession more than those of the public, the

public interest will prevail.

Returning to medical education, its ultimate goal is to promote improvement in the health of the public; however, it is necessary to look at performance in identifying the educational needs of physicians. The emphasis, formerly on how much the practitioner knows, should be on how he uses his knowledge in solving his day to day problems, for even new knowledge acquired may not be relevant to that physician's patients' needs. What is not known is how to prevail on the physician to use educational materials. Eliciting the motivation to bring this about is what we must strive to secure. Competency in our changing profession is our goal. The method by which competency is achieved is irrelevant. Conferring with the professional educator should aid in developing what might be the most productive methods of rendering evaluation reliable and valid. Mandatory interval re-examination appears essential.

Finally, there is no way the quality of an encounter between a physician and a patient can be monitored, overseen, judged or directed by anyone other than a practicing physician. It is crucially important that physicians do the job responsibly, for under the new legislature, PSRO, or Professional Standards Review Organization is the last chance physicians will have to control their own professional destinies. The congress is saying to the medical profession, "We will give you the authority and resources you need to assure the public that the medical care you provide Medicare and Medicaid patients is appropriate and of good quality." If we doctors fail to take this challenge seriously, and if we fail to make it work, it is obvious that review by laymen will come next. Peer review does not connote regulatory or punitive activity, but qualitative care appraisal; instead of a demeaning activity, it should be a truly educational one. Continuing medical education belongs not to the researcher, the lecturer or the academician, but to the recipient, and the profession of medicine requires a lifetime of learning. C.M.C.

# Improving Our Medical Records

## Option or Obligation?

Assessing the quality of patient care, needs of health professionals in continuing education, and effectiveness of educational programs designed to fulfill needs are among the major problems facing our nation's health care delivery system. They have attracted the concerns and commitments of institutions, organizations and individuals representing the consumers and providers of health care within that system. The American Society of Internal Medicine is playing an important role in describing and identifying problems, assigning priorities, evolving methods of solution and evaluating process in an attempt to deal more effectively with the major problems.

Within this context, the medical record has become an object of sharp focus. The medical record, properly organized and maintained, provides a rational basis for an analysis of private practice and institutional practice behavior related to patient care, and for assessment of the quality of patient care, educational needs and educational program effectiveness. To facilitate the analytic process, Dr. Lawrence Weed, Professor of Medicine at the University of Vermont, has developed a new system of medical record maintenance. The central feature of the system is the medical record's orientation around clearly identifiable problems which the patient presents. A problem list is composed for each patient being cared for, with each problem numbered and titled. This list is derived from a data base consisting of information obtained from the history, physical examination, laboratory, x-ray services, etc. The numbered and titled problem list is kept at the front of the record and includes active as well as resolved

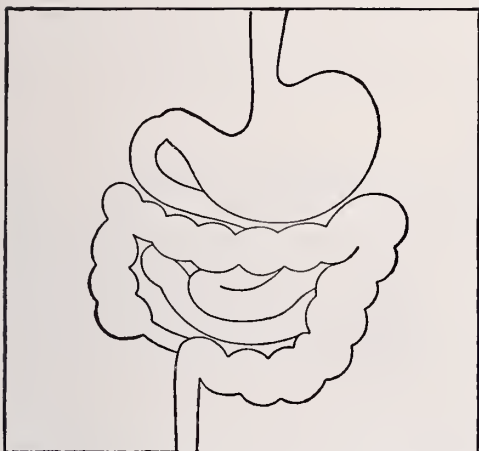
problems. The list may change as the data base changes or as different problems become more clearly inter-related. Initial plans, progress notes and discharge summaries are all oriented around specific problems.

This system of medical record maintenance undoubtedly enhances the usefulness of medical records. These important documents, the only ones available to reflect the nature of the process and outcome of patient care, should mirror accurately patient care behavior. Guess work can be kept to a minimum. It should only be necessary to review a medical record in order to determine whether care has met accepted standards of quality; to focus on defined needs in continuing education; and to assess effectiveness of on-going programs in continuing education.

Dr. Weed asserts that form enhances efficiency. Others, committed to large private practice activities, are not convinced that it is important to learn new approaches when everything seems to be going along satisfactorily. Whether or not you choose to apply Dr. Weed's system is not as relevant as the issue which relates to the responsibility you have to insure that your medical record accurately reflects the quality of care you provide your patients. It is likely that systematizing your approach to medical record maintenance will facilitate the fulfillment of this responsibility. You are likely to find that the effort required to create and maintain a better medical record will, in itself, prove to be an important continuing education activity for you.

ARVEY I. ROGERS, M.D.  
MIAMI

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ROBITUSSIN-DM <sup>®</sup>	●	●		●		●
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## Letters

Dear Editor:

Several members of the psychiatric staff of our hospital, together with the Administrator, have asked me to inform you of the recent visit to our community of a Paul Goulet. This individual had represented himself as a child psychiatrist, and either had or was eligible for a Florida license. The investigation by the members of the medical staff and Administrator led them to conclude that he was a fraud and not a physician, and they felt that this information should be passed on to the appropriate medical bodies.

COURTLANDT D. BERRY, M.D.  
NAPLES

To the Editor:

The Florida Medical Association has given to us a copy of a letter addressed to the Department of Professional And Occupational Regulation, Florida State Board of Medical Examiners, in which an answer is requested to the following question:

"My question is whether a medical partnership between a licensed practicing M.D. and the estate or surviving spouse of a deceased partner would be in violation of any canon of professional ethics or regulation governing the practice of medicine in the state of Florida if the sole and only purpose for the continuation of the partnership relationship is Federal Income Tax accounting and if the surviving spouse or estate of the deceased partner has no authority or control over the practice of the partnership and they are partners only for so long as it is necessary to liquidate a specific dollar amount established as the worth of the deceased partner's interest in the partnership."

It is our understanding that Dr. George S. Palmer as Executive Director of the Board of Medical Examiners and also Dr. Vincent P. Corso as Chairman of the Judicial Council of the Florida Medical Association have written you indicating that they believe this is more a question of law rather than one of medical ethics. We certainly agree with this conclusion because just as in a law partnership, a deceased professional's estate cannot engage in the practice of the profession. On the other hand, we know of no legal restriction upon any agreement which the professional partners may have made concerning the disposition of one partner's interest upon his death. In short, it is our belief and understanding that the medical partnership of two or more practicing physicians would cease for professional purposes upon the death of the partners; however, under an appropriate partnership agreement or other contract, the deceased partner's interest might be purchased or the deceased partner's widow or estate might be compensated on any legitimate basis such as a pro rata share of the accounts receivable, the fair market value of the assets of the partnership, etc.

We trust that the foregoing fully answers your inquiry.

MARKS, GRAY, CONROY & GIBBS  
DELBRIDGE L. GIBBS

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### REMINDER . . . . .

Send in your favorite photographs or color slides which might be appropriate for the cover of the JOURNAL. They will be handled with care and returned to you.



**Who  
killed  
the  
wicked  
itch**

(and the infection)\*

**?**

**snow white**  
**Sporostacin Cream**

TRADEMARK

(chlordantoin 1% and benzalkonium chloride 0.05%)

After you write your prescription for two tubes of soothing, fungicidal Sporostacin Cream, tell your patient not to be fooled by the quick relief of symptoms it affords. Make sure she knows how to use it as directed—for the *full* 14-day course of therapy. Then, on follow-up, you'll usually find that nonstaining, easy-to-use Sporostacin Cream has finished off vulvovaginal candidiasis in the nicest possible way.

**two tubes...two weeks**



\*

**Indication:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:  
“Probably” effective: For the treatment of vulvovaginal candidiasis.  
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** None known. **Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued. **Dosage:** One applicatorful intravaginally twice daily for a period of 14 days. Course of therapy may be repeated if necessary.

**Ortho Pharmaceutical Corporation • Raritan, New Jersey 08869**



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## ORGANIZATION

*EDITOR'S NOTE: Governor Reubin O'D. Askew was a guest speaker at the Florida Medical Association's 98th Annual Meeting. This summary of the critique prepared by Dr. William M. C. Wilhoit of Pensacola is published at the request of the FMA's Board of Governors.*

Governor Askew stressed the fact that hospital costs in Florida are up 75% in a five year period, 1965 to 1970, and that medical care costs have increased twice as fast as the cost of living. He fails to realize or emphasize that these increases have resulted primarily from the minimum wage—a legislative politico-union endorsed fact—and the socialistic trend in America exemplified by Medicare which physicians opposed. This is accompanied by high premium rates for malpractice insurance for physicians and hospitals. Perhaps, unrealistically, the Governor has not considered that the consumer pays ultimately. The quality of medical care is improved when those in the professions providing it take pride in the services they render rather than a short week, minimum wage, pay for overtime—generally, more pay for less work. I believe that as the minimum wage increases, unionization, government control, and state and federal medical programs grow, the efficiency in medical care delivery will decrease. The trend is present throughout this country.

After recommending Health Maintenance Organizations as the great solution to the medical profession's problems, Governor Askew uses the Group Health Cooperative of Puget Sound as an example of an HMO which proves that members spent only one third the national average number of days in the hospital per capitation. At a meeting in Las Vegas in January 1972, the medical director of the Cooperative stated that the plan was not an HMO but a co-op. This means that the consumer has considerable input into its operation in contrast to an HMO which really provides prepaid care on a per capita contract basis between some entity and the patients for physician and hospital services. Usually the agreement is written for at least one year.

The Governor should be congratulated for believing in a pluralistic system of medical care; however, he does not back up his belief. He stated he was seriously considering an HMO for all state employees and for Medicaid patients as well. An HMO should be blocked for state employees unless they have the opportunity to receive the

same funds to purchase other hospital and surgical insurance in a pluralistic arrangement.

I was impressed that his address generally emphasized not what the individual can do to prepare for catastrophic illness but the intention of the state and national government in the months and years ahead to take care of the individual.

He stressed the Health Planning Council which is an excellent idea provided it is not used to discourage competition or more efficient utilization of facilities with lower overhead. For example, a national corporation specializing in management and building hospitals took over a hospital in the Miami area. Recently day rates were reduced as a result of more efficient management. This lesson should not be lost upon a Health Planning Council which might be utilized to prevent more satisfactory but less expensive facilities.

There is another anachronism of patient care by physicians. Big government wants to tax heavily the individual who has the highest income; yet, the physician with above average income usually works harder, longer hours and sees more patients. Our socialistic system discourages more work for additional pay, thereby encouraging the very thing it criticizes. If there were some incentive basis which would allow physicians to retain income, many would extend their hours, increase the number of patients, and thereby allow less grounds for criticism. Due to the tax structure at present, most physicians probably could take two months vacation per year with little loss of net income.

As an attorney Governor Askew should realize that the legal profession in its ready acceptance of litigation against physicians as well as hospitals has helped to increase the cost of medical care and also the premiums for automobile insurance. Due to the current trend in these fields, there is a near parallel in the astronomic rise in malpractice premium rates as compared with automobile insurance rates.

William M. C. Wilhoit, M.D.  
► 1750 Palafox Street, Pensacola 32501.

# Encounter under the Scanning Electron Microscope



## SEM reveals changes in *E. coli* exposed to antibacterial agents

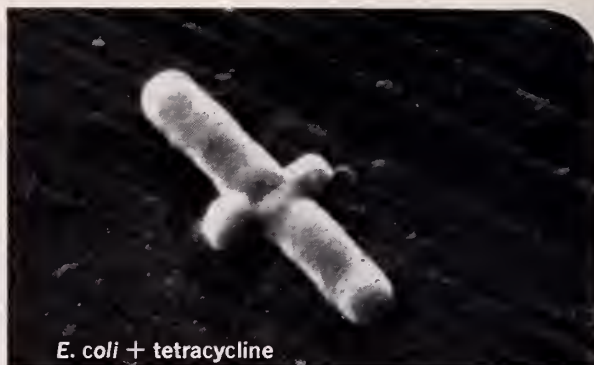
The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in

detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.





*E. coli* + sulfamethoxazole



*E. coli* + tetracycline



*E. coli* + cephalothin



*E. coli* + ampicillin

## Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,<sup>1-3</sup> strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of

its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

It should be noted that no clinical conclusions can be drawn from this study, as it is not always possible to extrapolate *in vitro* data to humans.

**References:** 1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971. 2. Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother.*, 1:164, 1972. 3. Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been estab-

lished. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purp or jaundice) may indicate serious blood disorders. Frequent and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom drug-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** Blood dyscrasias (agranulocytosis)



# Encounter in Clinical Practice

## Control of primary bacterial offenders

Antibacterial Gantanol® (sulfamethoxazole) controls susceptible strains of *E. coli* and other gram-negative and gram-positive organisms

often implicated in acute nonobstructed pyelonephritis and cystitis.

## Prompt antibacterial blood and urine levels

In from 2 to 3 hours after the initial 2-Gm adult dose, antibacterial levels are present in

both the blood and urine.

## B.I.D./T.I.D. dosage for around-the-clock coverage

Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8h. dosage regimen. Either schedule provides coverage during the waking

and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

## Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often re-

spond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents including sulfonamides, especially in chronic or recurrent u.t.i.

## Your Option: Tablets or Suspension

Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide

therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

**In nonobstructed cystitis and pyelonephritis due to susceptible organisms**

**Gantanol®**  
(sulfamethoxazole)  
**Basic Therapy**

ic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *skin reactions* (erythema multiforme, skin eruptions, epidermolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctivitis and scleral injection, photosensitization, arthralgia and myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and colitis); *CNS reactions* (headache, peripheral neuritis, depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periarteritis nodosa and phenomenon). Due to certain chemical similarities with goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of hypothyroidism, goiter production, diuresis and hypoglycemia as well as thy-

roid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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® **BLUE SHIELD**

# The Florida Combined Insurance Agency, Inc.

## Its Relationship With Florida Blue Cross — Blue Shield

JOSEPH G. MATTHEWS, M.D.

Florida Blue Cross and Blue Shield founded the Florida Combined Insurance Agency in 1965 at a time when group cancellations were increasing and demands of a changing, highly competitive market were resulting in business losses. Employers were insisting on a "package" concept offering life, accident, disability and health insurance with one carrier, one billing and one representative. The Florida Combined Insurance Agency was thus formed to meet competition from commercial carriers.

Prior to incorporation, one foremost concern was the Blue Cross-Blue Shield nonprofit status. Another was the fear that close affiliation to a commercial type insurance operation might dilute the Blue Cross-Blue Shield image. A complete merger of such activity therefore, with Blue Cross-Blue Shield operations was not possible. After thorough investigation of other plans, the most attractive appeared to exist in North Carolina, the Chapel Hill Plan with a general insurance agency that had been functioning successfully for 12 years.

The 1965 certificate of incorporation stated: "the general nature of the business to be transacted by the Florida Combined Insurance Agency

is to aid and promote the business of Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc., and specifically to act as agent or broker in the business of life, casualty, accident and health, fire insurance and all other types of insurance, group, individual or otherwise, and to carry on the business of agent or broker for any person, firm or corporation doing said business."

The total capital stock of the Agency is owned 50% by Blue Cross and 50% by Blue Shield. Legally, however, it is a completely separate entity as required to avoid interfering with Blue Cross-Blue Shield's nonprofit status. The Agency is located outside the Blue Cross-Blue Shield building, has its own billing, account system, mail and stock facilities, and in-house computer. It employs 44 people whose salaries are paid from operating income.

The Agency has a 11 member board of directors, five representing the Blue Cross board, five the Blue Shield board, and one representing both. Included from Blue Cross are: Frank J. Kelly, Miami attorney; Don Laurent, Sarasota hospital administrator; H. P. Osborne Jr., Jacksonville attorney; C. Sweet Smith Jr., Cocoa businessman, and John F. Wymer Jr., West Palm Beach hospital administrator. Representing Blue Shield are: Robert E. Zellner, M.D., Orlando, presently chair-

Dr. Matthews is a member of the Board of Directors, Blue Shield of Florida, Inc.

man of the Agency's Board; I. Barnett Harrison, M.D., Tallahassee; Warren W. Quillian, M.D., Coral Gables; Arthur W. Saarinen, Fort Lauderdale, and Circuit Court Judge Ben C. Willis, Tallahassee. J. W. Herbert, Jacksonville, represents both boards.

Initial total capitalization was \$10,000—\$5,000 contributed by Blue Cross and \$5,000 by Blue Shield. This fund remains as Blue Cross-Blue Shield stockholder equity in the corporation.

After considering 12 companies, the Agency selected the American Bankers Life Assurance Company of Miami, a legal reserve life insurance company incorporated under Florida law in 1952 to underwrite the life, accident and disability lines. The firm operates on a general agency basis throughout 49 states, District of Columbia, and Canada. It has a field sales force of more than 1,000 agents but none are group salesmen in Florida.

With positive endorsement from Blue Cross-Blue Shield management, the Agency has shown gratifying growth. It now has 5,500 billed accounts, that is, accounts with Blue Cross-Blue Shield health coverages plus some form of life,

accident or disability insurance. Agency production averages 50 to 60 new accounts per month, over 85% of these are new Blue Cross-Blue Shield groups. Annual premium billed and collected is approximately \$27 million—\$22 million in premium collections for Blue Cross-Blue Shield and \$5 million in premium on the life, accident and disability coverages. The current volume of life insurance in force is approximately \$580 million. The Agency has paid out almost \$10 million in life, accident and disability claims.

For the years 1965-1971 the profit and loss picture was largely on a break-even basis, but for 1972 the underwriting situation looks good. Profits beyond required operating expenses will be diverted to Blue Cross-Blue Shield through dividends. Hopefully, from a long-range point of view, such funds could mean a significant step toward more liberalized benefits for Blue Cross-Blue Shield subscribers. The sole reason for the Agency's existence is to help improve Blue Cross-Blue Shield's position in the highly competitive insurance market.

► Dr. Matthews, 1315 South Orange Avenue, Orlando 32806.

# THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY 36th Annual Meeting — March 19-22, 1973 The Fairmont Roosevelt Hotel

## GUEST SPEAKERS

Walter C. Bauer, M.D., St. Louis, Mo.

### **Pathology**

Max D. Cooper, M.D., Birmingham, Ala.

### **Pediatrics**

Robert S. Eliot, M.D., Omaha, Nebraska

### **Internal Medicine**

C. F. Gastineau, M.D., Rochester, Minn.

### **Internal Medicine**

Joseph D. Godfrey, M.D., Buffalo, N. Y.

### **Orthopedic Surgery**

James L. Grobe, M.D., Phoenix, Arizona

### **General Practice**

Kenneth K. Keown, M.D., Columbia, Mo.

### **Anesthesiology**

John M. Knox, M.D., Houston, Texas

### **Dermatology**

Harold I. Lief, M.D., Philadelphia, Pa.

### **Psychiatry**

William M. Lukash, M.D., Bethesda, Md.

### **Gastroenterology**

Richard F. Mattingly, M.D., Milwaukee, Wisc.

### **Gynecology**

A. J. McAdams, M.D., Pittsburgh, Pa.

### **Colon and Rectal Surgery**

Alden Miller, M.D., Los Angeles, Calif.

### **Otolaryngology**

Robert D. Moreton, M.D., Houston, Texas

### **Radiology**

Victor A. Politano, M.D., Miami, Fla.

### **Urology**

Worthington G. Schenk, Jr., M.D., Buffalo, N. Y.

### **Surgery**

W. A. J. Van Heuven, M.D., Albany, N. Y.

### **Ophthalmology**

George J. L. Wulff, Jr., M.D., St. Louis, Mo.

### **Obstetrics**

Robert Zeppa, M.D., Miami, Florida  
**Surgery**

Special Lecture by Dr. William M. Lukash, White House Physician and Head, Gastroenterology Clinic and Research Branch, U. S. Naval Hospital: "Observations of Chinese Medicine"

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This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by The American Academy of Family Physicians.

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Ethinyl Estradiol	0.005 mg.
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Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg.
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg.
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

**ACTION AND USES—DOSAGE:** 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy.

**AVAILABLE:** Bottles of 30, 100, and 500 tablets.

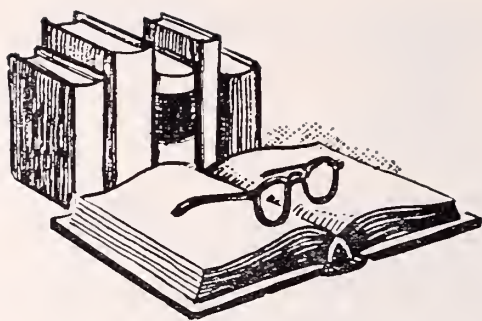
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Pioneers in Geriatric Research







## Book Reviews

**The Voice of the Symbol**, by Martin Grotjahn, M.D.  
224 Pp., Price \$8.00. Los Angeles, Mara Books, 1971.

I am an unabashed admirer of Dr. Grotjahn because of his previous book, *Beyond Laughter*, McGraw-Hill, 1957, now published in paperback. *Beyond Laughter* is a delightfully written book dealing with all aspects of humor, including sexual humor, in a witty, succinct style.

*The Voice of the Symbol* is not like that at all. This book is, in fact, a collection of 10 essays dealing with such apparently diverse subjects as television, contemporary American history, dreams, psychoanalytic theory and marriage. Unification is attempted through the thread of the symbolic in each of these subjects. The essays on Symbols of Love and Life in the Creative Marriage and From the Age of Anxiety to the Millennium of Mastery had the most meaning for me since they were written from the point of view of the physician seeing various aspects of the human condition. His insights and comments touched and enlarged some beginning insights I was already forming.

There are chapters on the symbolic in painting and thought. He gives a description of the painting, done around the year 1500, by Heironymus Bosch—a medieval painter whose work is strikingly like that of our contemporary Salvador Dali. Georg Groddeck, “mad” analyst and somewhat exasperating friend of Sigmund Freud, is delightfully described as a persistent symbol seeker. Apparently the painting of Bosch and the writing of Groddeck represent the essence of the symbolic to the author.

Dr. Grotjahn, senior psychoanalyst, teacher and writer gives his unique insights and personal views on a variety of subjects. Perhaps there is a symbol or two here to pique your interest.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Biochemical Profiling in Diagnostic Medicine**  
by Joseph A. Preston, M.D. and David B. Troxel, M.D.  
Pp. 51. Price \$2.50. Tarrytown, New York, Technicon Instruments Corporation, 1971.

How nice it would be if the practice of clinical medicine grew simpler. Even nicer would be a method by which the implications of clinical chemistry as applied to a well person or the sick person could be simplified. This booklet, published by the manufacturer of one of the automated chemistry instruments, sets forth biochemical patterns of a variety of normal and abnormal states. Employing the instrument which they manufacture, they have published a series of graphs reporting various biochemical alterations in health and disease. Having wrestled with both the technical and clinical problems inherent in the interpretation of biochemical profiles, I feel the implications of patterns should be taken with more than a grain of salt. More specifically, variations in normal values (i.e., age, sex, state of nutrition, time of day, etc.), inaccuracies and often undetected mechanical and optical problems, influence of medication, drugs and other external variables, both on the sample and on the patient, make “pattern” recognition and interpretation extremely risky.

This reviewer feels that there is no simple way to interpret the clinical significance of apparent chemical abnormalities and that the net effect of “profiling” is to compound rather than to simplify the infinite variations found in the practice of clinical medicine.

COURTLANDT D. BERRY, M.D.  
NAPLES



**The Truth About Vitamin E** by Martin Ebon. 149 Pp. Price \$1.25. New York, Bantam Books, Inc., 1972.

Although the author states that his answers will be cautious he seems to impugn that anyone not taking Vitamin E can be diagnosed across a city square.

This book relates that Vitamin E is of good use in arteriosclerosis, cerebral and coronary thrombosis, angina pectoris, gangrene, congenital and rheumatic heart diseases, diabetes, mental and breathing problems because it reduces the amount of oxygen required by all body tissues. It improves circulation, skin diseases, prevents miscarriages and is great for sex. Vitamin E creates complete mental and physical well being.

The author's statements are documented by references to mainly animal experiments in this country and on humans from exotic investigators. His book is concise, written for the laity and worth reading. You may succumb as I!

EDWARD M. REPP, M.D.  
POMPANO BEACH

**Diseases of the Digestive System**, Second Edition, by S. C. Truelove, M.D., F.R.C.P. and P. C. Reynell, M.D., F.R.C.P., 760 Pp. Price \$23.50, Blackwell Scientific Publications, Oxford; U. S. distributors F. A. Davis Company, Philadelphia, 1972.

This single volume text by two outstanding physicians from University of Oxford presents information on gastroenterology in a clear, succinct fashion. The authors state in the preface to the first edition "this book is meant primarily for senior students who wish to learn more than is in the ordinary general textbook of medicine and for young doctors with a budding interest in gastroenterology. It may, also, be of some interest to the established general physician."

Chapters are concise and to the point. References to the literature are complete to 1970. The authors state in the preface to the second edition . . . " . . . we have done our best to keep it compact, as it is intended to be read and not to be a reference book."

This book is highly recommended for students, house officers and physicians who see patients with gastrointestinal complaints.

F. NORMAN VICKERS, M.D.  
PENSACOLA

## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Current Pediatric Diagnosis Treatment**, 2nd Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. Pp. 1008. Illustrated. Price \$12.00. Los Altos, California, Lange Medical Publications, 1972.

**Laboratory Medicine Hematology**, Fourth Edition by John B. Miale, M.D. Pp. 1318. 1399 Illustrations. Price \$27.50. St. Louis, The C. V. Mosby Company, 1972.

**Symposium on Aesthetic Surgery of the Face, Eyelid, and Breast**, Volume Four. Edited by Frank W. Masters, M.D. and John R. Lewis Jr., M.D. Pp. 222. 446 Illustrations. Price \$35.50. St. Louis, The C. V. Mosby Company, 1972.

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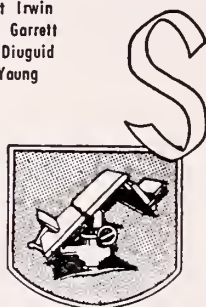
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- 11-16 Eighth Annual Postgraduate Course "Internal Medicine 1973," Sheraton Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33153.
- 19-21 Ear Surgery Course, St. Joseph's Hospital, Tampa. For information: J. Brown Farrior, M.D., 509 Bay at Bayshore Blvd., Tampa 33606.
- 19-24 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## MARCH

- 14-17 Fifth Teaching Conference in Clinical Cardiology, Sheraton Four Ambassadors Hotel, Miami. For information: Michael S. Gordon, M.D., Box 875, Biscayne Annex, Miami 33152.
- 19-24 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.
- 26-31 Selected Topics in Genitourinary Roentgenology, Playboy Plaza Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.

## APRIL

- 16-21 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## MAY

- 29-31 Master Interpretation of Clinical Electrophysiology, Contemporary Hotel, Disney World, Lake Buena Vista, Florida. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## FEBRUARY

- 4-10 Midwinter Seminar in Ophthalmology and Otolaryngology, Americana Hotel, Miami Beach. For information: Kenneth S. Whitmer, M.D., 550 Brickell Ave., Miami 33131.
- 25-Mar. 3 Contemporary Medicine and Surgery, Fontainebleau Hotel, Miami Beach. For information: John Bellows, M.D., 30 N. Michigan Ave., Chicago 60602.
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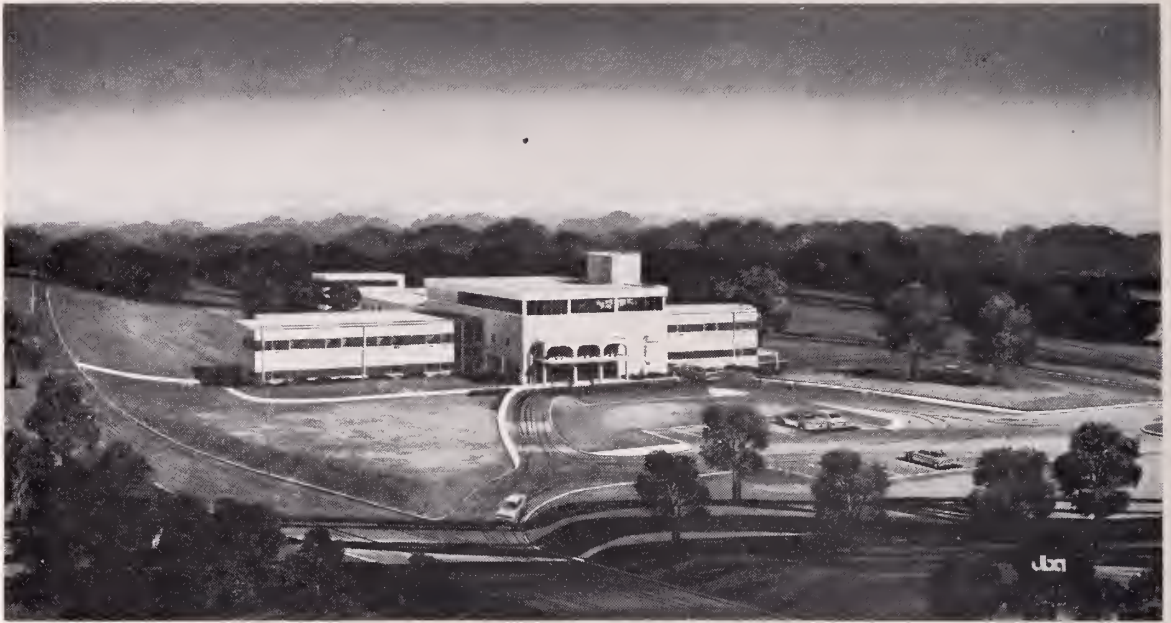
## MARCH

- 11-15 International Anesthesia Research Society, Americana Hotel, Miami Beach. For information: B. B. Sankey, M.D., 3645 Warrenville Center Rd., Cleveland 44122.

## MAY

- 3- 5 Association of Clinical Scientists, Hawaiian Village, Tampa. For information: F. William Sunderman Jr., M.D., University of Connecticut School of Medicine, Drawer B., Newington 06111.
- 3- 7 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. For information: Robert D. Reinecke, M.D., Albany Medical College, Albany, N. Y. 12208.
- 6-12 American Society for Microbiology, Fontainebleau Hotel, Miami Beach. For information: Mr. R. W. Sarber, 1913 I St., N.W., Washington, D. C. 20006.
- 12-14 American Association of Blue Shield Plans, Diplomat Hotel, Hollywood, Fla. For information: Jean A. Borger, 211 E. Chicago Ave., Chicago 60611.
- 21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.





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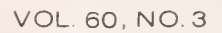
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MARCH 1973

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**MARCH COVER** — PSRO is a term that will be heard frequently in the coming months. It stands for Professional Standards Review Organization. Vested in PSRO by federal law is the authority for conduct of professional review of all aspects of health care delivery for Medicaid and Medicare recipients. See article page 34 and editorial page 45.



## President's Page



### Do We Need Blue Shield

This would seem to be a strange question to be raising, but a few doctors over the state have asked this. It is true that Blue Shield has come under attack and received criticism from our membership, mainly because it has been the carrier for Medicare. There is no doubt that many frustrations related to the Medicare program and the method of payment have been taken out on Blue Shield rather than the government; some of this criticism may be justified, most is not.

I was serving on the Blue Shield Board in 1966 when the Florida Medical Association House of Delegates voted to ask Blue Shield to become the carrier for Medicare. Dean Steward was president of Blue Shield, and he pointed out that if Blue Shield, "the doctors' plan," became involved with the federal Medicare program the Blue Shield image with the doctors would suffer. All of us on the Board at that time realized this, but believed that since the Florida Medical Association had asked Blue Shield to take on this responsibility, we should do it. The Blue Shield Board was of the opinion then, as I believe they still are, that the physicians of Florida would be better served using Blue Shield as a buffer between them and the federal government, than some other insurance company over which the medical profession would have no control whatsoever. The Blue Shield Board is made up predominantly of physicians who are elected by all of us in the Florida Medical Association. These doctors are a part of us and have the same goals and desires we all have.

With the assumption of the massive federal program, Blue Shield has had to increase its own staff tremendously. There are currently from 50 to 100,000 claims handled for Medicare Part B each week. Since its inception in 1966, Blue Shield has paid out \$675 million to the doctors of Florida. With this tremendous workload, plus computerization and many recently hired clerks, there is little wonder some mistakes are made. In addition, the weekly changing regulations of the federal government to which the carrier is subjected, make the task of keeping everyone happy almost a nightmare at times.

With these thoughts in mind, the current Chairman of the Board of Blue Shield, Dr. Robert Zellner, asks both your FMA Board of Governors and the Blue Shield Board if they believe Blue Shield should continue the contract with Medicare when the time for re-signing arrives this summer. In spite of all the problems created by a massive federal program of this type, I am convinced that Florida medicine needs Blue Shield just as much now, or possibly more, than we did in 1966. I say, let's re-sign the contract and keep working with Blue Shield in an effort to make the program work.

*William J. Dean, M.D.*

# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions

# A New Dosage Form:

## Chewable Tablets 500 mg Mintezol® THIABENDAZOLE | MSD)



so easy to take  
everyone in the family  
can keep to the  
regimen you prescribe

side: fever, facial flush, chills, conjunctival injection, edema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.  
plied: Chewable tablets, containing 500 mg thiabendazole, boxes of 36, strip packaged, individually foil wrapped; suspension, containing 500 mg thiabendazole per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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addendum

## INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	1/2
50	0.5	1
75	0.75	1 1/2
100	1.0	2
125	1.25	2 1/2
150 & over	1.5	3

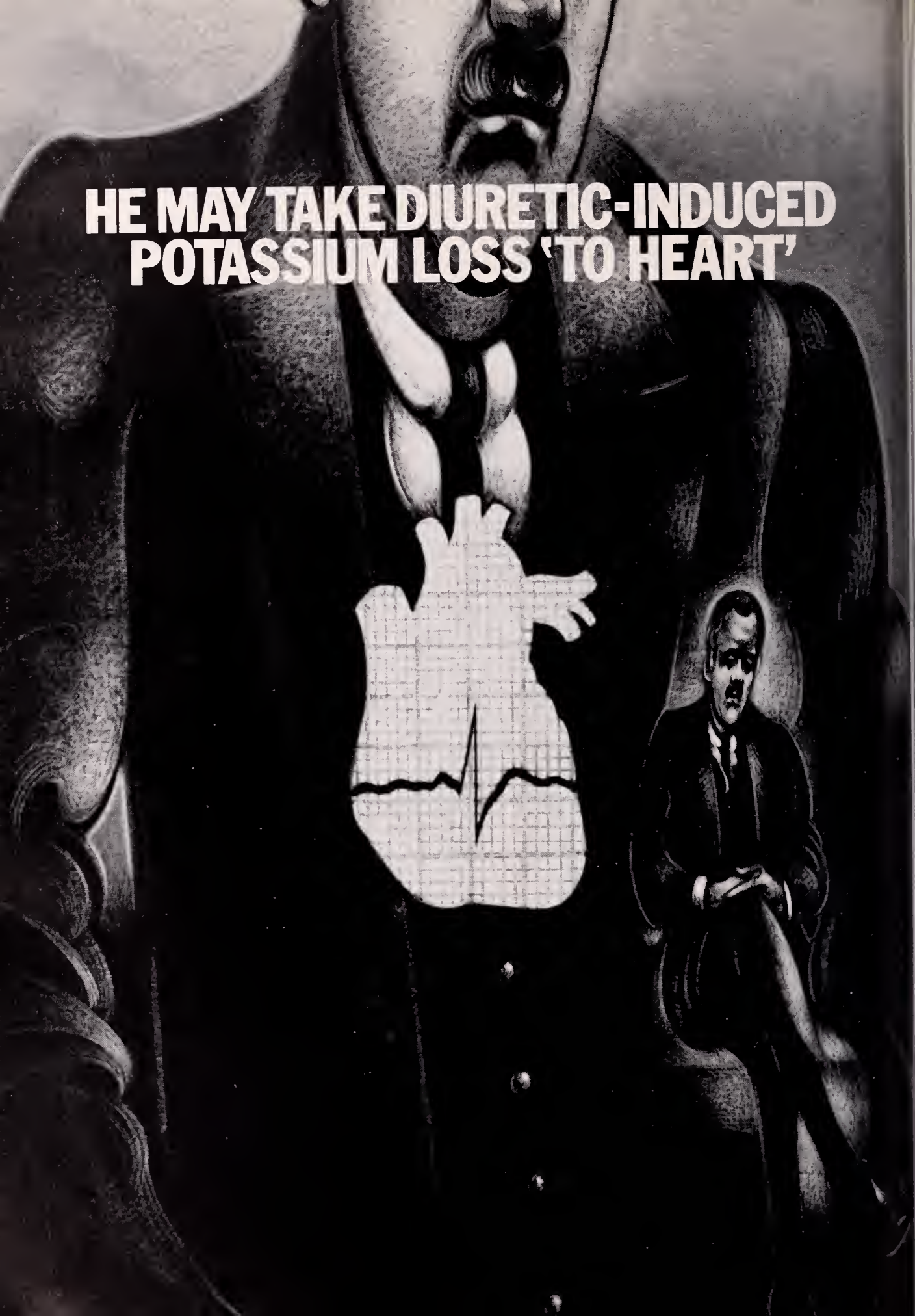
The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



# HE MAY TAKE DIURETIC-INDUCED POTASSIUM LOSS 'TO HEART'



# AVOID POTASSIUM DEFICIENCY WITH...

## K-LYTE<sup>®</sup> OR K-LYTE/CL<sup>®</sup>

potassium supplement                      potassium supplement *with* chloride

Manifestations of potassium deficiency may range through a variety of signs and symptoms including muscular weakness and fatigue...cardiac alterations discernible by characteristic ECG tracings...impaired mental function and diminished reflexes...impaired respiration...anorexia and abdominal distention.

The etiology of hypokalemia is also broad, encompassing a number of clinical conditions. But most important of all may be a course of treatment that causes excessive loss of body potassium—such as thiazide diuretics and corticosteroids.

No matter what the etiology, the solution is usually *potassium supplementation*.

What better way to supplement than with K-LYTE or K-LYTE/CL. Effervescent K-LYTE tablets supply the usually recommended dose of 50 mEq. potassium daily in just two tablets. When chloride is also desirable, K-LYTE/CL provides it in the preferred 1:1 ratio to potassium. Both forms are accurate and reliable sources of electrolyte replacement. Administration in "pre-dissolved" form reduces the potential for G.I. irritation. Finally, you have a choice of three delicious flavors—a taste of oranges, tangy lime or fruit punch—all good enough to drive a patient to drink.

**K-Lyte<sup>®</sup>** Each effervescent tablet in solution supplies 25 mEq. potassium as bicarbonate and citrate

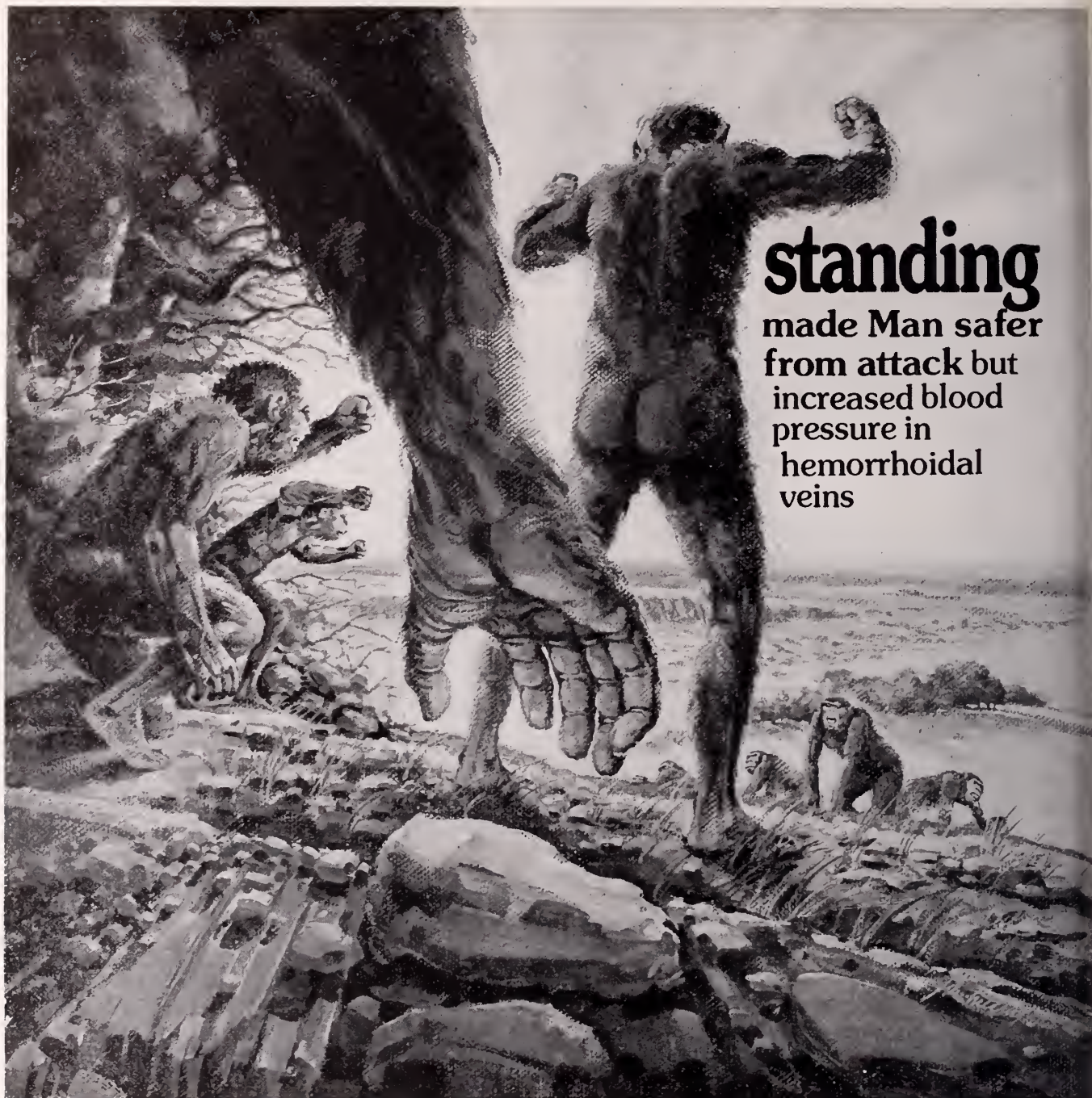
**K-Lyte/CL<sup>®</sup>** Each dose of powder in solution supplies 25 mEq. potassium chloride

Each tablet or dose must be completely dissolved before taking.

Indications: K-Lyte and K-Lyte/CL are oral potassium supplements for therapy or prophylaxis of potassium deficiency. Particularly useful when thiazide diuretics or corticosteroids cause excessive excretory potassium losses. Contraindications: Impaired renal function with oliguria or azotemia; Addison's disease; hyperkalemia from any cause. Warnings and Precautions: Since the amount of potassium deficiency may be difficult to determine accurately, supplements should be administered with caution, and dosages adjusted to the requirements of the individual patient. Potassium intoxication rarely occurs in patients with normal kidney function. Symptoms of potassium intoxication are variable. They include listlessness, mental confusion, and tingling of the extremities. Frequent checks of the clinical status of the patient, ECG, and serum potassium level are desirable. In established hypokalemia, attention should also be directed toward other potential electrolyte disturbances. Potassium supplements should be given cautiously to digitalized patients. To minimize the possibility of gastrointestinal irritation associated with the oral ingestion of concentrated potassium salt preparations, patients should be carefully directed to dissolve each dose completely in the stated amount of water. K-Lyte/CL contains approximately 20-25 Calories of sucrose per dose which should be considered for patients with restriction of caloric intake. Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort may occur with the use of potassium salts. Dosage and Administration: Adults: 1 tablet or dose *completely dissolved*, 2 to 4 times daily, depending upon the requirements of the patient: K-Lyte: 1 tablet (25 mEq. potassium) in 3 to 4 ounces of cold or ice water; K-Lyte/CL: 1 dose (25 mEq. potassium chloride) in 6 ounces of cold or ice water. The normal adult daily requirement is approximately 50 mEq. of elemental potassium. NOTE: It is suggested that these products be taken with meals and sipped slowly over a 5-10 minute period. How Supplied: K-Lyte: Effervescent tablets—boxes of 30 and 250 (orange or lime flavors). K-Lyte/CL: Powder, cans of 30 measured doses with scoop (fruit-punch flavor). R

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made Man safer  
from attack but  
increased blood  
pressure in  
hemorrhoidal  
veins

#### Precaution

Prolonged or excessive use of Anusol-HC might produce systemic corticosteroid effects.

Symptomatic relief should not delay definitive diagnosis or treatment.

#### Dosage and Administration

**Anusol-HC:** One suppository in the morning and one at bedtime for 3 to 6 days or until the inflammation subsides.

**Regular Anusol:** one suppository in the morning, one at bedtime, and one immediately following each evacuation.

## to help ease acute symptoms of **Anusol-HC**

**Hemorrhoidal Suppositories with Hydrocortisone Acetate. On your Rx only!**  
Each suppository contains hydrocortisone acetate 10 mg; bismuth subgallate 2.25%; bismuth resorcin compound 1.75%; benzyl benzoate 1.2%; Peruvian balsam 1.8%; zinc oxide 11.0%; and boric acid 5.0%; plus the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland hydrogenated vegetable oil base containing cocoa butter.

## for long-term patient comfort **Anusol**

**Suppositories and Ointment** Each suppository or gram of ointment contains the active ingredients of an Anusol-HC suppository minus the hydrocortisone.

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ANGP 33



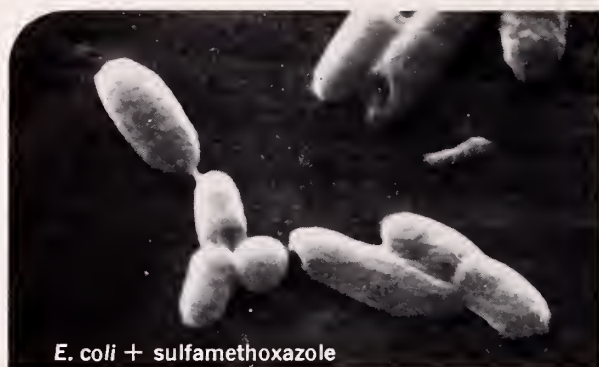
# Encounter under the Scanning Electron Microscope



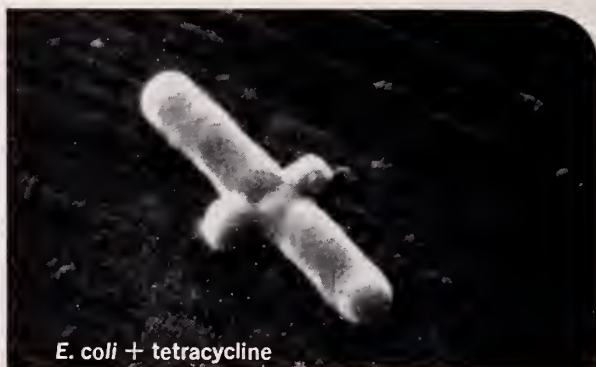
## SEM reveals changes in *E. coli* exposed to antibacterial agents

The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in

detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.



*E. coli* + sulfamethoxazole



*E. coli* + tetracycline



*E. coli* + cephalothin



*E. coli* + ampicillin

## Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,<sup>1-3</sup> strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of

its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

It should be noted that no clinical conclusions can be drawn from this study, as it is not always possible to extrapolate *in vitro* data to humans.

**References:** 1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971. 2. Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother.*, 1:164, 1972. 3. Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media.** The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been estab-

lished. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpur or jaundice) may indicate serious blood disorders. Frequent CB and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias* (agranulocytosis)



# Encounter in Clinical Practice

## Control of primary bacterial offenders

Antibacterial Gantanol® (sulfamethoxazole) controls susceptible strains of *E. coli* and other gram-negative and gram-positive organisms

often implicated in acute nonobstructed pyelonephritis and cystitis.

## Prompt antibacterial blood and urine levels

In from 2 to 3 hours after the initial 2-Gm adult dose, antibacterial levels are present in

both the blood and urine.

## B.I.D./T.I.D. dosage for around-the-clock coverage

Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8 h. dosage regimen. Either schedule provides coverage during the waking

and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

## Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often re-

spond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents including sulfonamides, especially in chronic or recurrent u.t.i.

## Your Option: Tablets or Suspension

Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide

therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

**In nonobstructed cystitis and pyelonephritis due to susceptible organisms**

**Gantanol<sup>®</sup>**  
(sulfamethoxazole)  
**Basic Therapy**

lastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *ergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and colitis); *CNS reactions* (headache, peripheral neuritis, meningeal depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, acute nephrosis with oliguria and anuria, periarteritis nodosa and Raynaud phenomenon). Due to certain chemical similarities with other goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thy-

roid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley N.J. 07110



## **Medical News**

### **Aging Council Elects Mr. Nixon**

Mr. Eugene L. Nixon of Jacksonville, Director of the Scientific and Medical Services Department of the Florida Medical Association, has been named President-Elect of the Florida Council on Aging. At an indefinite later date, Mr. Nixon will succeed Mrs. Rowena E. Rogers, R.N., of Clermont.

### **Cardiology College Inducts**

Three Florida physicians, all members of the Florida Medical Association, are among 94 doctors who recently were granted Fellowship in the American College of Cardiology.

Thomas C. Dickinson, M.D., of Orlando, ACC Governor for Florida, identified the new Fellows as: Morton Korn, M.D., and Clyde D. Schoenfeld, M.D., both of Miami Beach; and Joseph A. Ezzo, M.D., of St. Petersburg.

### **AMA Committee Terms Revised**

The American Medical Association Board of Trustees has adjusted the terms of members of councils and committees in the wake of new policy. Terms are now limited to seven years for council members and five years for committee members.

Florida members of AMA councils and committees will attain maximum tenure in the years indicated as follows:

Granville W. Larimore, M.D., Tampa, Council on Environmental, Occupational and Public Health (1973); Francis C. Coleman, M.D., Tampa, Council on Health Manpower (1973); and H. Phillip Hampton, M.D., Tampa, Council on Legislation (1973).

Roy M. Baker, M.D., Jacksonville, Committee on Community Emergency Services (1976); and James W. Walker, M.D., Jacksonville, Committee on Nursing (1975).

### **Cancer Seminar**

"GI Tract Cancer" will be the theme of the 7th Professional Cancer Seminar to be held Saturday, March 17, 1973 at the Port-O-Call Resort Inn, St. Petersburg. The professional cancer seminar is co-sponsored by the American Cancer Society, Pinellas County Unit, Florida Academy of Family Physicians and the University of South Florida College of Medicine.

### **Dr. Schiff Receives Award**

Leon Schiff, M.D., Professor of Medicine at the University of Miami School of Medicine has been chosen to receive the Friedenwald Medal by the American Gastroenterological Association.

The award will be presented to Dr. Schiff at the AGA's Annual Meeting in May for "outstanding achievement in gastroenterology." Dr. Schiff went to Miami from the University of Cincinnati, where he was Professor Emeritus of Medicine.

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laxative/stool softener  
with a more effective,  
dual-action formula.



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**GERI-CASAGRA™ (CASANTHRANOL) 30 mg. • DIOCTYL SODIUM SULFOSUCCINATE 250 mg.**

The unique Stimulax formula provides the ideal combination of a proven, gentle laxative with a sufficient dosage of stool softener for dependable, effective relief of constipation.

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killed  
the  
wicked  
itch**

(and the infection)\*  
**?**

**snow white**  
**Sporostacin Cream**

TRADEMARK

(chlordantoin 1% and benzalkonium chloride 0.05%)

After you write your prescription for two tubes of soothing, fungicidal Sporostacin Cream, tell your patient not to be fooled by the quick relief of symptoms it affords. Make sure she knows how to use it as directed—for the *full* 14-day course of therapy. Then, on follow-up, you'll usually find that nonstaining, easy-to-use Sporostacin Cream has finished off vulvovaginal candidiasis in the nicest possible way.

**two tubes...two weeks**



\*

**Indication:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

"Probably" effective: For the treatment of vulvovaginal candidiasis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** None known. **Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued. **Dosage:** One applicatorful intravaginally twice daily for a period of 14 days. Course of therapy may be repeated if necessary.

**Ortho Pharmaceutical Corporation • Raritan, New Jersey 08869**



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# FEEDBACK -from Pearl Street

## Influenza Up-Date

Reported influenza-like disease activity continues to lag behind that recorded last flu season. Acute respiratory disease is fairly widespread and scattered in Florida; there are very occasional foci of heavy activity. However, areas which earlier had reported great activity are now showing a general declining trend and the new areas of activity are similar in number and distribution to the ones that they have replaced. Epidemic-type rapid transmission remains notable for its continued absence. Serologic data, reflecting the etiology of respiratory disease experienced in Florida during the latter half of January, now show a significant increase in the number of recent influenza A cases. Confirmation of recent influenza A infection is now available for several cases from Miami Beach, Jacksonville, Naples, Clearwater and Tarpon Springs. Two sets of sera from a U. S. Navy vessel collected during an outbreak of influenza-like disease aboard ship, have confirmed the outbreak as recent influenza A. Isolations of influenza A virus have been made in Miami from passengers returning from a cruise in the Caribbean and in Gainesville from University of Florida students and their families. Additionally, three cases of parainfluenza I infection have now been documented, adding to the multiple agents already known to be circulating in the state.

The local picture at the present time generally reflects the national situation. Over half the states are reporting moderate outbreaks of influenza or influenza-like disease, but in most areas the morbidity and excessive mortality figures are smaller than last year. Only the Far West Pacific Coast area appears to be at all heavily affected. Oregon and Wisconsin, besides Hawaii, are the only states reporting confirmed influenza B at this time.

## "Decimal System" for Diabetics—

For many years commercially available injectable insulin preparations for the management of diabetes mellitus have been popularized in two concentrations, 40 and 80 units per cc. Since insulin is a potent drug, errors in dosage frequently have serious sequelae. The 40 and 80 unit

scales employed with current insulin concentrations are unique to this preparation and hence are awkward and cumbersome for a population with a high prevalence of decreased visual acuity generally accustomed to using a decimal scale in most other situations. Additionally, the inadvertent substitution of U-40 for U-80 insulin (or vice versa) has long been a relatively common and hazardous occurrence.

The American Diabetes Association and the Florida Diabetes Association have recently recommended the adoption of a single concentration of insulin at 100 units per cc in the interest of decreasing the frequency of dosage errors. Within several months U-100 insulin will be made available in the United States and Canada by at least two manufacturers. Simultaneously, U-100 syringes, both disposable and reusable, will be introduced by the syringe manufacturers. The final goal is general usage of U-100 insulin in all types (plain, NPH, PZI, and lente) and the discontinuation of other preparations together with the corresponding syringes.

## *Vibrio parahaemolyticus*—

*Vibrio parahaemolyticus* is a short gram negative curved motile rod with high saline tolerance. It is a major cause of acute gastroenteritis in the Far East where marine products are frequently consumed raw. The disease produced by this organism is characterized by short incubation (usually less than one day), severe abdominal cramps, nausea, occasional vomiting, and diarrhea. Fever is generally absent. Outbreaks of acute gastroenteritis attributable to *V. parahaemolyticus* are being reported with increasing frequency in the U. S., but have never been conclusively proved in Florida. Nevertheless, the organism is here and has been cultured from Gulf water. Routine stool cultures for enteric pathogens will not recover this organism and if *V. parahaemolyticus* is suspected the physician must make note of this on his laboratory request slip.

Epidemiologically, the most common thread in U. S. outbreaks has been recontamination of already cooked seafood, notably crabs, by placing them back in the contaminated baskets which formerly held the live animals.



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## The Catch . . .

An issue on which the 92nd Congress did not act—and which, as a result, will be near the top of the agenda for the 93rd—is the thorny question of medical care. The nation's health is bound to be the theme of one of the watershed debates of the 1970s, and, whatever answers emerge from the debate, they are likely to determine the level of medical care in the United States for years to come.

The choices before Congress and the nation range all the way from, on the one hand, maintaining the present system of substantially private medicine to, on the other, adopting a system of publicly financed health care for everyone. There are, of course, dozens of other plans between those two extremes.

As the American people ponder the issue and assess the various recommendations that will be coming to the fore, they need to remember that there are, at bottom, three fundamental elements to consider in connection with medical care—quality, availability, and cost. There is little real debate that the national goal ought to be the most comprehensive sort of medical care for every man, woman, and child in the nation—regardless of where he lives or his economic circumstances—at a cost within his reach.

*If we maintain that top-quality care should be equally available to everyone, it must be obvious that the amount of time available to each—and the quality of attention and care available to each—must diminish correspondingly. Costs are multiplied, and quality is significantly impaired.*

*If, finally, we cheapen the cost of medical care, we invite an impairment of both quality and availability. Cutting all physicians' fees in half would.*

Pursuing the goal of the best possible care for everyone at the lowest possible cost becomes, in this light, far more complex than many Americans suppose. As the great medical-care debate unfolds in the months and years ahead, Americans may be called upon to make some far-ranging choices from among objectives that are often mutually exclusive. The choices they ultimately make are choices which they and their families will have to live *with* for generations to come.

LEES M. SCHADEL JR., M.D., *Editor*  
FORT LAUDERDALE

Reprinted from The Record, Official Bulletin Broward County Medical Association, January 1973

# Rondomycin<sup>®</sup>

## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin<sup>®</sup> (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin<sup>®</sup> (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** Rondomycin<sup>®</sup> (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

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## Arteriosclerotic Aneurysm of the Axillary Artery

DANIEL B. NUNN, M.D.

**Abstract:** The axillary artery is an unusual site for aneurysmal dilatation to occur. Arterial trauma is the most common cause for an aneurysm in this location; arteriosclerosis is a rare causative factor.

A case report is presented of an axillary artery aneurysm caused by arteriosclerosis treated successfully by surgery using the technique of endoaneurysmorrhaphy and saphenous vein graft replacement. Nonreversal placement of the vein graft with reversal of the vein valves was helpful in compensating for a significant disparity in size between the axillary and brachial arteries. The clinical findings and surgical treatment in patients with an axillary artery aneurysm are discussed.

This paper reports the successful treatment of an arteriosclerotic aneurysm of the axillary artery by endoaneurysmorrhaphy and saphenous vein graft replacement.

Arteriosclerosis is a rare cause of aneurysmal dilatation of the axillary artery. In a review of the English medical literature from 1950 to the present, I was unable to find any such report.

### Case Report

A 78-year-old Caucasian female was hospitalized on February 16, 1970 because of a painful pulsatile mass in the right axilla. The mass had been present for an indeterminate period, but was said to have increased in size five to six days prior to admission. The patient complained of pain in the right hand, and the pain was accentuated when she attempted to close her hand. There was no history of trauma or recent fever.

Physical examination revealed a tender pulsatile mass, measuring 10 x 5 cm. in the right axilla. The overlying skin appeared normal, and a systolic bruit was audible. Satisfactory radial pulses were present and equal bilaterally. Supine blood pressure was recorded as 170/84 in the right arm and 180/84 in the left arm. The heart seemed clinically enlarged, and a faint systolic murmur was detected at the point of maximum impulse. A normal sinus rhythm was present at a rate of 72 beats per minute. The remainder of the physical examination was not remarkable. The initial clinical impression was: (1) aneurysm of the right axillary artery with recent expansion or leakage and (2) arteriosclerotic heart disease.

Chest films showed left ventricular enlargement. An electrocardiogram revealed changes indicative of left axis deviation and left ventricular enlargement. The routine serology test for syphilis was nonreactive. Arteriograms of the right subclavian, axillary and brachial arteries were obtained by percutaneous needle puncture of the subclavian artery followed by hand injection of 20 ml. of 60% Renografin; serial films were made with an Elema-Schonander unit. The arteriograms confirmed the presence of an axillary artery aneurysm, and there was no radiographic evidence of leakage (Fig. 1).

Surgery was performed on February 23, 1970 using general endotracheal anesthesia (Fig. 2). The skin incision was begun parallel to the inferior surface of the right clavicle and curved inferiorly over the anterior shoulder. The incision was continued across the axilla, parallel to the skin creases, and extended for a short distance along the vertical axis of the right arm on the posterior medial aspect. The pectoralis major and minor muscles were divided near their insertions and reflected inferiorly. The axillary artery, proximal to the aneurysm, and the

From the Department of Surgery, St. Vincent's Medical Center, a member of the Jacksonville Hospitals Educational Program, Jacksonville.





Fig. 1.—Arteriogram showing axillary artery aneurysm.

brachial artery, distal to the aneurysm, were mobilized and encircled with umbilical tapes. The proximal axillary artery measured 10 mm. in diameter and the brachial artery 5 mm. in diameter. Dissection of the aneurysm disclosed a severe degree of inflammatory reaction in the surrounding tissues, but there was no evidence of recent hemorrhage from the aneurysm. Complete excision was thought to be inadvisable because of the inflammatory reaction and the proximity of the aneurysm to the brachial plexus nerve trunks. Vascular clamps were placed across the proximal axillary and brachial arteries following which the arteries were divided immediately proximal and distal to the aneurysm. The anterior wall of the aneurysm was incised, thrombus evacuated from the lumen, and arterial branches originating from the aneurysm closed with interrupted 3-0 Ethiflex figure-of-eight sutures. A portion of the aneurysmal wall was excised to obtain a specimen for pathological and bacteriological study. A saphenous vein graft was removed from the right thigh. The graft was sutured end-to-end first to the proximal axillary artery then to the brachial artery using continuous 6-0 Ethiflex cardiovascular sutures (Fig. 3). Since the proximal portion of the vein graft was significantly larger in diameter than the distal portion, the graft was not reversed in order to compensate for the disparity in size between the axillary and brachial arteries. The valves in the vein graft, however, were reversed

prior to completion of the distal anastomosis by retrograde passage of a Fogarty embolectomy catheter followed by withdrawal of the catheter with the balloon inflated. Before closing the operative wound, the position of the vein graft was checked with the arm completely adducted. Bowing was noted but no kinking. The patient withstood the operative procedure well, and a strong right radial pulse was present after surgery. The pain in the right hand gradually disappeared over the next few days. The operative specimen showed gross and microscopic changes of severe arteriosclerosis; no organisms were cultured.

At the last follow-up examination two years after surgery, the patient was asymptomatic with respect to the right shoulder and upper extremity. A strong right radial pulse was still present, and there were no abnormal physical findings in the vicinity of the vein graft.

### Discussion

The axillary artery is an unusual site for aneurysmal dilatation to occur. The majority of peripheral aneurysms, irrespective of their etiology, occur in the lower extremities. Those caused by arteriosclerosis are particularly rare in locations other than the popliteal or femoral arteries. In a report of 107 peripheral aneurysms treated by Crawford, DeBakey and Cooley,<sup>1</sup> none involved the axillary artery.

The etiologic factors responsible for aneurysmal dilatation of the axillary artery include trauma,<sup>2-9</sup> infection, periarteritis nodosa, congenital arterial defects,<sup>10</sup> and arteriosclerosis. Trauma is most common and may entail either penetrating or nonpenetrating injury. Most of the reported cases of traumatic axillary artery aneurysm have been associated with a penetrating arterial injury often from a knife or bullet wound.<sup>2-4,7,9</sup> Arteriosclerosis may be a contributing factor in the development of any axillary artery aneurysm; however, arteriosclerosis alone seldom causes an aneurysm in this location.

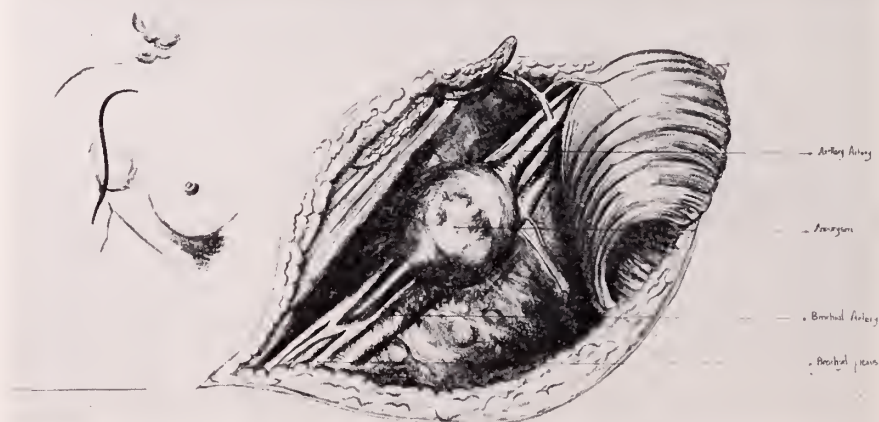


Fig. 2.—Diagram of surgical incision and operative findings.

The clinical findings in patients with an axillary artery aneurysm are generally well-defined. A pulsatile mass is present in the axilla, and a systolic bruit is frequently audible over the mass. The patient may experience pain in the axillary mass and the ipsilateral upper extremity. The pain is usually due to compression of the brachial plexus nerve trunks by the adjacent aneurysm and is often accentuated by various movements or positions of the upper extremity. Also, pain may indicate recent expansion or leakage of the aneurysm or nerve injury in traumatic cases. Motor weakness and sensory loss in the upper extremity are sometimes present and can be explained on the basis of either nerve compression by the aneurysm or actual nerve injury. Patients with an axillary artery aneurysm caused by arteriosclerosis are usually elderly, and frequently have associated heart disease, hypertension, and aneurysms at other sites.

Serious complications may develop in these patients including permanent damage to the brachial plexus nerve trunks, thrombosis of the aneurysm, peripheral embolization from the aneurysm,<sup>11</sup> and rupture of the aneurysm. Rupture, thrombosis, and peripheral embolization commonly produce arterial insufficiency in the ipsilateral upper extremity.



Fig. 3.—Diagram showing endoaneurysmorrhaphy and insertion of saphenous vein graft.

Arteriograms are desirable to confirm the diagnosis and to allow for an evaluation of the proximal and distal arteries. Findings of occlusion of the main arteries distal to the aneurysm should not be considered a contraindication to surgery. The occlusion is frequently due to emboli which can be removed with subsequent restoration of blood flow.

In 1823 Key<sup>5</sup> successfully treated a traumatic axillary artery aneurysm by ligation of the third part of the subclavian artery. Collateral circulation was sufficient to maintain the viability of the upper extremity, and the patient did not experience further difficulty for 12 years when he died from unrelated causes. The current surgical treatment for an axillary artery aneurysm involves either resection of the aneurysm or an endoaneurysmorrhaphy and restoration of blood flow preferably through the use of a saphenous vein graft. Peripheral emboli, if present, are removed with Fogarty catheters. Endoaneurysmorrhaphy rather than excisional therapy should be employed in cases, such as the one presented, in which the aneurysm cannot be safely dissected from the brachial plexus nerve trunks. The use of a vein graft instead of a dacron prosthesis decreases the possibility of graft occlusion due to kinking when the upper extremity is adducted. As mentioned in the case presented, nonreversal placement of the vein graft with reversal of the vein valves may be helpful in compensating for a significant disparity in size between the axillary and brachial arteries.

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# Mallory-Weiss Syndrome Presenting as a Gastric Tumor

CARMELITA R. ESPIRITU, M.D., JOSE MENDOZA, M.D. AND CHARLES J. GRATZ, M.D.

**Abstract:** Mallory-Weiss Syndrome is characterized by massive hematemesis following laceration of the gastroesophageal area associated with or induced by retching or forceful vomiting. A case of a 72 year old man with history of hematemesis, not accompanied by retching or vomiting is presented. Esophagoscopy revealed an irregular mass at the cardio-esophageal junction. An upper G.I. series confirmed a large, irregular polypoid, filling defect in the gastric fundus, interpreted as either a polypoid adenocarcinoma

or a submucosal leiomyoma. At exploration, there were no masses seen but there were linear tears at the esophago-gastric junction. The diagnosis of Mallory-Weiss syndrome was not entertained because of the absence of history of retching or induced vomiting. Absence of the history however, by no means rules out the condition. The possibility of a hematoma, secondary to Mallory-Weiss Syndrome should be considered in the differential diagnosis of tumors in the gastric cardia.

Mallory-Weiss syndrome is characterized by massive hematemesis following laceration of the gastroesophageal area associated with/or induced by retching or forceful vomiting.<sup>1</sup> This paper describes an additional case without history of retching or forceful vomiting and presenting with a mass in the cardia, radiologically.

## Case Report

A 72-year-old man admitted to Mount Sinai Hospital's Emergency Room one hour after sustaining an injury to the nose and forehead in a fall, vomited 500-700 cc. of bright red blood, not accompanied by retching. He denied a history of gastrointestinal diseases.

Physical examination showed a well-developed, well-nourished male, blood pressure 130/70, pulse rate 80 per minute, regular. Tilt test was negative. There was a 1½ cm. laceration on the forehead with evidence of bleeding. Heart and lungs were normal. Abdomen was soft, flat, nontender, liver and spleen not palpable, bowel sounds normal. Extremities showed no edema. Rectal examination revealed a large prostate. Laboratory data on admission showed hemoglobin 11 Gm. and hematocrit 40.2 with WBC of 5,800 and normal differential count. Urinalysis was normal. BUN, electrolytes, SGOT, LDH, CPK, alkaline phosphatase, bilirubin, creatinine and uric acid, cholesterol, total protein and albumin were all within normal limits; PT 12/12. Esophagoscopy with the Olympus (Model GFB) fiberoptic scope showed the distal esophagus to be covered with fresh blood and visualization was difficult. Active bleeding was demonstrated around the cardio-esophageal junction. A mass was seen at the cardioesophageal junction adhering to the underlying mucosa with an

irregular border and with superficial ulcerations. A biopsy was performed. Microscopic examination of the tissue demonstrated debris of stratified squamous epithelium of the esophageal mucosa. An upper gastrointestinal series performed two hours later, after the patient's condition had stabilized, demonstrated a large, irregular, polypoid filling defect in the gastric fundus interpreted as either polypoid adenocarcinoma or submucosal leiomyoma (figs. 1, 2). On exploration of the abdomen, the stomach was inspected from the esophagogastric junction to the pylorus and no tumor was found. There were three linear erosions of the esophagogastric junction which were sutured. Post-operative course was uneventful.

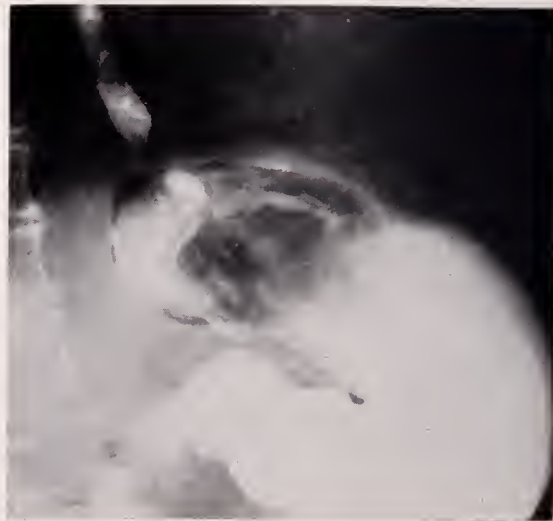


Fig. 1.—Barium study of the stomach in the lateral view showed a large intraluminal defect in the cardia which splits the barium stream. No mucosal folds are identified.

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Fig. 2.—The same finding in the RAO position.

### Discussion

A number of reports describing lesions in the gastric-cardia interpreted as neoplasm appeared in the literature in the last ten years. Numerous lesions have been described as simulating gastric tumors near the gastric end of the stomach.<sup>2</sup> Among them are those caused by extrinsic structures originating in the liver, spleen or kidneys,<sup>3,4</sup> and by splenic artery tortuosity.<sup>5</sup> Intrinsic gastric lesions such as varices, polyps and benign ulcers have also been reported.<sup>6</sup> However, there is no mention of hematomas secondary to Mallory-Weiss syndrome. Because of active bleeding from the gastro-esophageal junction, lacerations were not visualized in the distal esophagus of our patient.

The diagnosis of Mallory-Weiss syndrome was not entertained because of the absence of history of retching or induced vomiting. Absence of this history, however, by no means rules out the condition. The stratified squamous epithelium demonstrated on biopsy could have been from the sloughing of the esophageal mucosa as a result of the tear. The confirmation of the presence of a tumor lesion in the gastric cardia is the single most important diagnostic study. Repeat upper gastrointestinal series with special attention to this area is the simplest way to do it.

The possibility of a hematoma secondary to Mallory-Weiss syndrome should be considered in the differential diagnosis of tumors in the gastric cardia.

### Summary

A case is presented of a patient with Mallory-Weiss syndrome who had no history of retching or forceful vomiting but evidence of a gastric tumor.

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**A MORATORIUM ON PSRO IMPLEMENTATION** by state and county medical societies was called for at the first meeting of the AMA Advisory Committee on Professional Standards Review. At the meeting held in January at AMA headquarters, the 23-member committee agreed that a moratorium is necessary because there is no national administrator of the PSRO program and there are no national guidelines for establishing PSROs.



# Congenital Atresia of the Colon

FRANK RODRIGUEZ, M.D. AND CURTIS M. PHILLIPS, M.D.

**Abstract:** Atresia of the colon is a relatively rare occurrence. Prompt diagnosis and adequate treatment is a must for survival of the patient. Early diagnosis necessitates correct interpretation of history and physical findings. Radiographic studies of the abdomen demonstrating obstructive gas patterns as well as barium enema using approximately six inches of gravity pressure are extremely useful. Meticulous preoperative preparation of the patient with nasogastric suction and administration of fluids and electrolytes is essential. A two stage operation is recommended with decompression colostomy and second stage re-anastomosis. In the case presented a pull through procedure gave excellent results.

The reported incidences of all intestinal atresias varies from one to 1,500 to one to 20,000 births. Atresia of the colon comprises from 5% to 10% of the cases.

The first successfully treated infant for atresia of the colon was reported in 1922. Up to 1969, there have been 69 successfully treated cases of colonic atresia or stenosis reported.

## Definition

Atresia, absence or total closure of a normal opening, has two structural types: (1) in continuity and (2) without continuity. The former consist of a diaphragm-like occlusion of the lumen without disturbance of the external contour of the bowel other than the proximal dilatation and underdeveloped, collapsed bowel distally. Atresia without continuity consists of a total absence of a segment of bowel.

## Embryology

The roof of the entodermal yolk sac folds into a tubular gut which becomes the digestive tract

and respiratory system. Therefore, in embryos of four weeks (5 mm.) the intestine is a simple tube, beginning at the stomach and ending in the cloaca. Between the fifth week and birth, the intestine increases its length 1,000 times while the small intestine becomes six times the length of the large intestine. The small intestine is originally thicker than the large intestine and it is not until the fifth month that the large intestine becomes greater in diameter. Proliferation of the epithelial lining of the duodenum leads to its occlusion in the sixth and seventh weeks, but vacuolation soon restores a continuous lumen. All of the small and large intestines show a similar phenomenon, but in lesser degree. Failure to recanalize is believed to result in atresia, that is, occlusion of the lumen, while total absence of the segment is thought to be caused by ischemia occurring at an early stage of development.

The following case is reported because of its rarity.

## Report of Case

The infant, a baby boy, was a product of a gravida 3, para 2 mother who went through an uneventful pregnancy and delivered spontaneously. The birth weight was 9 lbs. 2 ozs. and the APGAR score was 10. The only physical abnormality at birth was reported as an undescended right testicle and underdeveloped penis.

Seventeen hours after birth, the infant began to vomit yellowish material and became distended. Rectal examination at this time demonstrated an obstruction at 2 cm. with rectal sphincter intact. Radiographic studies of the abdomen demonstrated gaseous distention of what appeared to be small bowel and small bubbles of gas in the region of the distal colon. No gas was seen in the rectum. A barium enema was attempted with a soft #18 Foley catheter introduced 2 cm. into the rectum where an obstruction was encountered. Introduction of barium under six inches of gravity pressure showed a complete obstruction with a blind separated pouch.

Intravenous infusion was commenced and a nasogastric tube inserted. Exploratory laparotomy was performed 28 hours after birth. By means of a left paramedian incision the abdomen was entered. There was complete absence of the colon except for a small portion which measured 6 cm. and comprised the cecum and appendix. This 6 cm. blind pouch was in the left iliac fossa. There was no rectum only a cystic cord-like structure filled with mucus which measured 2 cm. in length (Fig. 1). A small stab wound was made in the left iliac area just inferior to the umbilicus and the cecum was brought out through this area and fixed to the peritoneum with interrupted 4-0 chromic catgut. A purse string suture of 4-0 chromic was placed in the cecum and a small #10 rubber catheter

Dr. Rodriguez was a senior surgical resident, Jacksonville Hospital Educational Program, now in private practice, and Dr. Phillips is chairman, Department of Surgery, Baptist Memorial Hospital, Jacksonville.

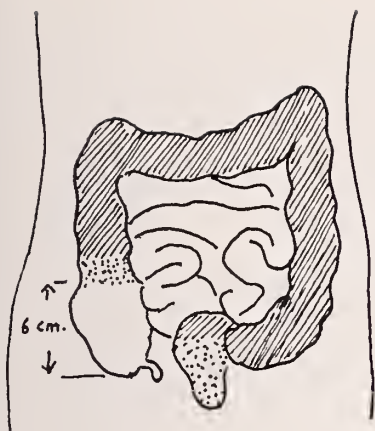


Figure 1

inserted and decompression of the bowel was obtained. Two days later, the rubber catheter was removed and the end cecostomy opening enlarged with cautery.

The postoperative course was uneventful except for urinary tract infection. The child began to tolerate his formula three days after the operation, gained weight, and was discharged with a functioning colostomy 16 days after surgery.

He was admitted again four months later and underwent a closure of colostomy with removal of the appendix and anastomosis of the 6 cm. portion of the right colon to the anus in a pull-through fashion. The child did well and was discharged ten days later having approximately four normal bowel movements daily.

The child was admitted four months later with urinary tract infection and a urological work-up demonstrated the long-suspected congenital urinary tract abnormalities. He was found to have absence of the right kidney, hypospadias and dilatation of the entire collecting system. The patient underwent exploratory laparotomy and lysis of adhesions was performed around the left ureter near the pelvic brim which was causing constriction. Previously he had undergone exploration of a mass in the left inguinal region with removal of a fibrotic testis.

## Results and Discussion

No similar case of successful treatment of atresia of the colon has been found in the literature. In the case presented here there was complete absence of most of the ascending colon and total absence of the transverse colon and the descending except for 2 cm. length of a cord-like residual structure containing mucous-like material which could be considered representing part of the rectosigmoid. There was also absence of the right kidney, hypospadias and fibrotic left testicle. Treatment consisted in a two stage procedure comprising a colostomy and a pull-through procedure with closure of the colostomy. At the time of this report, the child is doing well and having normal bowel movements through the anus. He is one year and four months old and has excellent sphincter tone.

## Summary

Colonic atresia is a rare anomaly. We present what we believe is an unreported variation of colonic atresia with successful treatment.

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A straight thinker can write clearly if he works at it. Only a few write easily, and even then they can improve their art with conscientious practice. But the literature of a maturing profession will be too meager a mark of its growth if we depend only upon the few with a natural inclination to write. The rest of us must push ourselves toward that culmination of successful action—communicating it to others who may test, modify, and use our experience. Too often we stop short.—Lucille Petry Leone, *J. Nursing*, October 1958.



# Effects of Marijuana Smoking on the Sleep EEG

## Preliminary Studies

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ROBERT L. WILLIAMS, M.D., JOHN I. THORNBY, PH.D., AND CAROLYN J. HURSCH, PH.D.

**Abstract:** The phenomenal increase in the social use of Cannabis, or marijuana, in the United States during the last decade presumably reflects in large part the attractiveness of the psychic (i.e., central nervous system) effects of the drug to users. In spite of the fact that technical problems in administering the drug and in measuring its effects make pharmacological studies of this substance particularly difficult, this upsurge in marijuana usage has stimulated much research in recent years. One of the more direct methods of assessing central nervous system effects in humans is by use of the electroencephalogram (EEG).

Clinical EEG's following marijuana smoking or oral administration of tetrahydrocannabinol (THC), which is thought to be the active ingredient in marijuana, have revealed a slight slowing of alpha frequencies.<sup>1,2</sup> However, Hollister et al.<sup>1</sup> noted that in their study the EEG changes resembled those of drowsiness and for this reason were not clearly distinguishable from EEG's made under placebo conditions in which drowsiness also occurred. This would also make it difficult to conclude whether or not marijuana has specific effects on EEG activity.

For several reasons the sleep EEG suggests

itself as a promising method of investigating the neurophysiological effects of this drug. Quite frequently the sleep EEG has proved to be more sensitive to pharmacological agents than the clinical EEG. In addition, drowsiness or sleepiness are frequent side effects of marijuana ingestion,<sup>3,4</sup> and we have recently become aware of the fact that some young adult insomniacs find marijuana to be the hypnotic of choice. This suggests that this agent might have detectable effects on EEG sleep patterns.

On the basis of this reasoning, we conducted the following two pilot studies of marijuana smokers in order to determine (1) whether or not there are immediate drug effects which are discernible in all-night EEG records, and (2) whether or not long-term users experience withdrawal effects which are discernible in all-night EEG records.

### Method

Of the marijuana smoking population available for study, 30 male smokers between the ages of 20 and 25 were selected who had been using marijuana at least five times per week for three months or more. Their anonymity was preserved throughout the study. A clinical interview and the 16 PF, a psychological profile, were administered to each smoker. Chronic smokers were compared with healthy males of similar age who did not smoke marijuana. All subjects were paid ten dollars per night to participate in the study. They reported to the sleep laboratory approximately one hour prior to their usual bedtime and were wired for EEG and electro-oculographic (EOG) recording of sleep patterns. They went to bed at their usual bedtime and arose or were awakened after their usual length of sleep. All were requested to refrain from taking naps and drugs and consuming

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alcoholic beverages throughout the study. The EEG-EOG recording and scoring techniques followed a modified version<sup>5</sup> of the Dement-Kleitman method.<sup>6</sup>

Two separate studies were conducted. Study 1: This study was designed to determine whether or not there are discernible immediate effects of marijuana smoking in chronic smokers. Each of ten chronic smokers and ten matched nonsmokers slept two consecutive nights in the sleep laboratory. Before retiring each night smokers were asked to smoke marijuana cigarettes until they reached a subjective "high." Nonsmokers simply reported to the laboratory for two nights of recorded sleep. Only the second night of data for both groups was used in the data analysis.

Study 2: This study was designed to determine whether or not there are discernible immediate withdrawal effects in long-term marijuana smokers. Twenty chronic smokers and 20 matched nonsmokers each slept two or three consecutive nights in the sleep laboratory. For subjects who slept two nights, only the second night of data was used in the data analysis. For those who slept three nights, the data for the second and third

nights were averaged for the data analysis. The chronic smokers had abstained from smoking marijuana during a 24- to 36-hour period prior to the second sleep night. Nonsmokers simply reported to the laboratory for two or three nights of recorded sleep.

Results

In each study differences on the following sleep variables were assessed with two-tailed t tests for independent samples:

- Time in Bed
- Sleep Period Time (The time between falling asleep at night and waking in the morning)
- Total Sleep Time
- Sleep Efficiency (Total Sleep Time divided by Time in Bed)
- Sleep Latency (The interval between going to bed and the onset of the first sleep stage)
- Number of awakenings during the night
- REM Period Length
- REM Interval Length (Time between successive REM periods)
- Percent Sleep Period Time of each sleep stage and waking stage 0
- Latency of each stage from sleep onset

Study 1: As is shown in Table 1, the only immediate effect of marijuana smoking in chronic smokers was a reduction in percent of stage 4 sleep from nonsmoker levels (p.<.01). The 16 PF scores were within the normal range for all variables.

TABLE 1.—MEANS, STANDARD DEVIATIONS, AND SIGNIFICANT DIFFERENCES<sup>a</sup> BETWEEN GROUPS.

SLEEP VARIABLE <sup>b</sup>	STUDY 1 <sup>c</sup>				STUDY 2 <sup>d</sup>			
	Smokers		Nonsmokers		Abstainers		Nonsmokers	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Time in Bed (min)	451.80	40.27	443.00	23.95	430.00	20.89	427.52	31.16
Sleep Period Time (min)	429.20	37.86	421.80	31.74	413.18	29.46	411.88	33.56
Total Sleep Time (min)	417.70	35.31	416.90	30.20	408.95	28.78	404.58	37.51
Sleep Efficiency	0.93	0.07	0.94	0.05	0.95	0.04	0.95	0.04
Sleep Latency (min)	17.00	17.28	19.70	20.47	16.55	17.16	14.10	13.03
Number of Awakenings	3.40	2.12	3.50	1.58	3.50	2.68	3.62	2.47
REM Period Length (min) <sup>e</sup>	26.26	8.51	22.94	5.20	25.78	8.20	28.83	6.71
REM Interval Length (min)	65.46	19.91	65.35	10.20	67.97	14.37	68.89	13.84
Percent Sleep Period Time								
Stage 0	2.60	3.49	1.13	1.29	1.01	1.16	1.82	2.71
Stage 1	5.30	3.84	3.99	1.31	4.35	1.90	4.29	1.80
Stage 1 REM	22.97	4.85	25.49	5.59	24.36	4.31	24.61	4.43
Stage 2	56.55 <sup>h**</sup>	10.26	48.42	5.95	47.10 <sup>i**</sup>	5.53	48.91	5.58
Stage 3	5.60	2.98	7.15	3.00	7.18	3.58	5.38	1.91
Stage 4	6.98 <sup>g**</sup>	5.62	13.82	4.25	15.99 <sup>i***</sup>	3.89	14.97	4.34
Latency from Sleep Onset (min) <sup>f</sup>	h***							
Stage 0	182.20	166.90	213.00	138.87	226.15	164.68	202.02	158.37
Stage 1 REM	121.30	57.10	82.80	32.09	88.78	40.00	104.80	31.76
Stage 2	13.60 <sup>h**</sup>	10.91	8.00	6.77	6.18 <sup>i**</sup>	2.79	6.48	4.59
Stage 3	30.80 <sup>h**</sup>	13.16	19.80	13.16	19.20 <sup>i**</sup>	6.02	17.80	5.62
Stage 4	39.44 <sup>h*</sup>	21.47	27.20	21.20	25.85 <sup>i*</sup>	12.26	23.48	7.12

a Two-tailed t tests for independent samples.  
b See text for definitions.  
c N=10 per group.  
d N=20 per group.  
e Excluding REM periods terminated by final morning awakening.  
f Latency to stage 1 omitted since stage 1 was entered first on all nights.  
g Significantly different from Nonsmokers.  
h Significantly different from Abstainers in Study 2.  
i Significantly different from Smokers in Study 1.  
\* p<.05  
\*\* p<.01  
\*\*\* p<.001



Study 2: Table 1 shows that there were no significant changes, relative to nonsmokers, in the sleep patterns of chronic marijuana smokers who had abstained from smoking from 24 to 36 hours. The 16 PF scores were within the normal range for all variables.

Study 1 vs. Study 2: In order to determine whether or not marijuana smoking by chronic smokers affected sleep patterns relative to chronic smokers who had abstained from smoking for 24 to 36 hours, and who were not significantly different from nonsmokers, the smokers in Study 1 were compared to the smoker-abstainers in Study 2. Table 1 shows that the smokers experienced significantly less stage 4 sleep ( $p < .001$ ) than the smoker-abstainers. This decrement in stage 4 was offset by an increase in stage 2 sleep ( $p < .01$ ). The smokers also experienced longer latencies to stage 2 ( $p < .01$ ), stage 3 ( $p < .01$ ), and stage 4 ( $p < .05$ ) sleep.

### Discussion

These data indicate that marijuana smoking before retiring by chronic smokers significantly decreases stage 4 sleep, both in relation to nonsmokers and to chronic smokers who have abstained from smoking from 24 to 36 hours. Whether the increase to nonsmoker levels of stage 4 sleep in the smoker-abstainers represents a rebound from chronic stage 4 sleep deprivation accompanying chronic marijuana smoking, or whether it simply represents a return to normal levels when marijuana is not smoked immediately before retiring, cannot be determined from this study. Nevertheless, these results imply that chronic marijuana smoking has no long-term, sustained effects on stage 4 sleep. These results are consistent with those of Zimmerberg et al,<sup>7</sup> who found that although ingestion of both marijuana and THC by Rhesus monkeys significantly impaired response rate and accuracy, there was no evidence of long-term effects, since performance always returned to normal on days immediately following drug administration.

We have no direct evidence that the reduction in stage 4 sleep experienced by the smokers in Study 1 represents a primary pharmacological effect of marijuana. However, it has been demonstrated that peak plasma concentrations of THC metabolites and maximal physiological and psychological effects occur within one to three or four hours following administration of the drug.<sup>8,9</sup> Since stage 4 sleep is concentrated in the first third of a normal night's sleep, there is strong

suggestive evidence that the reduction in stage 4 sleep does in fact represent a direct drug effect.

On the other hand, presleep anxiety has been shown to produce a reduction of slow-wave sleep.<sup>10</sup> It is possible that a certain amount of anxiety was inherent in the present experimental situation, since the chronic smokers were admitting to, and, in some cases, participating in, an illegal activity at the university where they were enrolled as students. Although an attempt was made to alleviate this anxiety by maintaining the anonymity of the smokers, it cannot be denied that anxiety may have contributed to the reduction in stage 4 sleep in the Study 1 smokers.

We have increasingly encountered young adult insomniacs who use marijuana for its hypnotic effects and who prefer it to other hypnotics. Although there was no significant change in sleep latency following marijuana smoking by the non-insomniac chronic smokers in Study 1, on the basis of our insomniacs' reports we would hypothesize that marijuana shortens sleep latency in individuals who have difficulty falling asleep. Furthermore, one of the reasons many of our insomniacs give for preferring marijuana is that it does not produce the usual drug hangover the following morning. This is particularly interesting in view of our evidence that this drug suppresses stage 4 sleep rather selectively if taken immediately before retiring.

In several recent studies of the effects of marijuana smoking or THC administration on sleep EEG patterns, the investigators have concentrated on REM sleep and have concluded that changes in this stage represent a primary pharmacological effect of these agents.<sup>11-13</sup> In neither of the present studies was there any evidence that the REM sleep of chronic smokers is affected by smoking marijuana or by acute withdrawal from it. Although the reports of two of the former studies<sup>12,13</sup> are too brief to be sure of all the procedural details, this discrepancy may well be attributable in part to the fact that in all three studies there were small numbers of subjects, differences in the degree of experience with the drug, and differences in the ages of subjects. Moreover, in all of the studies the effect on REM sleep either was not assessed statistically or was statistically nonsignificant. In the studies in which THC was administered orally<sup>11,13</sup> it is possible that the slight effect on REM sleep, which is normally concentrated in the later part of the night, reflected the fact that oral administration produces effects

somewhat later than does smoking marijuana.<sup>3</sup>

The present studies are considered to be preliminary because, due to certain administrative and technical difficulties, we were forced to have the smokers in Study 1 provide their own marijuana. Obviously this resulted in inadequate control of the quality and dose of the drug administered, and it is possible that individual doses of marijuana were adulterated with other psychoactive agents. However, even when more strict control of the quality of the material is possible, it is impossible to control the delivered dose by inhalation. Furthermore, the constituents of marijuana appear to be particularly unstable.<sup>3</sup> The difficulties inherent in the study of this drug are graphically demonstrated by the report of Rodin et al.<sup>2</sup> They had samples of NIMH-supplied marijuana, which was stated to contain 1.312%  $\Delta^9$ -THC, subjected to two independent assays. The results indicated that  $\Delta^9$ -THC content was .51% and .20%, respectively. This discrepancy probably reflects both the inadequate assay technique and the continuous biological conversions taking place in the material.

A further aspect of work with this drug which somewhat hinders full appreciation of the results is the fact that there is no objective method of measuring a marijuana "high." One is forced to rely, as we did, on the smoker's subjective opinion. However, Lemberger et al.<sup>8</sup> have recently reported that the psychological "high" correlates well with peak plasma levels of labelled metabolites of THC.

In spite of these important procedural difficulties, we feel that the consistency of the effect on stage 4 sleep in Study 1 can be most parsimoniously explained by attributing it to the common denominator of the experimental situation—the

inhalation of more or less pure marijuana to the point of a subjective "high." From this standpoint, these studies contribute new and intriguing information on the neurophysiological effects of marijuana. In our view, the fact that the mode of drug administration was more naturalistic than is the oral administration of purer marijuana extracts, lends further importance to our findings.

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A COMPUTERIZED MEDICAID PAYMENT SYSTEM, financed by HEW as a pilot program for a standard system to be used by all the states, has led to problems for the Ohio State Welfare Department and 22,000 health care providers throughout the state. While the Welfare Department geared up for the new system, an estimated \$39 million in claims piled up. From Sept. 1, 1972, when the system was scheduled to go into effect, until the end of the year, few claims were paid. A spokesman for the Ohio State Medical Association said some physicians have had to borrow money to keep their offices open. A Welfare Department official said the department hopes to have all back claims paid by May 1. He said the computerized system soon will return claims faster and cut yearly Medicaid costs by \$20 to \$40 million. A coalition composed of hospital representatives, physicians, pharmacists, dentists, medical suppliers and laboratories is seeking legislation that would remove Medicaid from the Welfare Department and place it with a private firm.



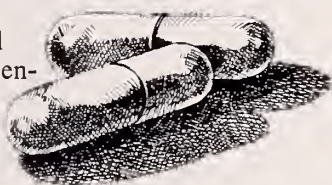
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**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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# Medical Review - Friend or Foe?

I. M. ESSRIG, M.D.

**ABSTRACT:** As a result of the recent enactment of H.R. 1 and its PSRO provisions, physicians are forced to accept increasing public demands for participation in the delivery and cost of medical care. Adequacy, distribution, quality and charges are now legally in the public domain, as ethically and morally they always have been.

Peer review is three quarters of a century old and can be used to meet this latest challenge, and those yet to come, if organized medicine addresses itself adequately to the task. Cost containment and predictability are both essential to estimate insurance premiums, and by now it is

apparent the public prefers this method of payment for health care.

The recently recognized advantage to physicians is continued medical education by computerizing and evaluating effectiveness of hospital use, self-determined standards of diagnosis and care, physician and patient profiles—all adding to quality practice methods. Resulting patient trust and confidence in the professional physician could well signal out the free enterprise fee-for-service system as the preferred method among the “pluralistic approaches” for medical care. A resolute response from Florida Medicine is indicated and likely will be forthcoming in the immediate future.

When I was first appointed to the infant Committee of 17 many years ago, originally formed by the Florida Medical Association to assist in preventing the collapse of Blue Shield, little envisioned was Medicare and Medicaid, catastrophic and National Health Insurance, Peer Review or PSRO, Mr. Kennedy and Mr. Bennett or, even less, HMOs and EMCROs. I have had the good fortune of serving with every chairman, from first to present, as well as the opportunity and privilege of associating with all of its many fine members until last May. Now, in October of the same year, the President has signed the 1972 Social Security Bill. PSRO is now Public Law 92-603. The AMA has already given it reluctant endorsement. Does organized medicine accept this as a friendly solution, or will the review process become a foe?

We initially were concerned about the rising

costs of hospital and medical care and its coverage by health insurance, service versus indemnity coverage, comprehensive coverage, relative value studies, hospital versus outpatient practice of medicine, over-utilization and sub-standard fees.<sup>1</sup> Social and political forces, at that time still under-way, have blossomed apparently into full flower. Hospital costs, then rising about 5% a year, rapidly rose to 15% annually and have remained at this level. Health care costs have gone from \$10 to \$20 billion to today's \$60 to \$70 billion. Surgical fees have approximately doubled, commercial goods (e.g., automobiles) have increased about 4 times while hospital charges have zoomed over ten-fold. Now new programs are estimated to raise total costs of health care to \$140-150 billion or more a year, some 8% to 10% of our gross national product. Yet, the ratio of physicians' charges has steadily decreased to 20% or less of the total figures. Nevertheless, we are

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Dr. Essrig is a member of the FMA Board of Governors.

under steadily increasing pressures to provide answers for cost containment as well as quality control, physician maldistribution, inadequacy of 24-hour comprehensive coverage and a host of other criticisms.

Who is to change whose life style? Is there any substitute for free choice or does anyone really believe that health is something that can be given or bestowed by one individual to another and does not have to be worked for and earned? An illuminating sidelight on this aspect of costs is revealed in a recent Intensive Care study at the Brigham Hospital in Boston where the director quizzed patients' families about their apprehension of the tremendous charges generated in such units. The average family had little concern about bills, ranging close to \$1,000 per day in some cases, because the patient was paying such a small percentage of the total amount.<sup>2</sup>

Can anyone other than the patient be responsible for his own health? And, as a corollary, can and will the physician with today's spotlight on public accountability adequately implement Peer Review? The Congress and the AMA say we will. Can we? Answers are too broad, complex and indefinite to permit definitive review, let alone simplistic answer, in any one article. Nevertheless, personal opinions at this time may be pertinent.

Members of the Florida Medical Association have a long history of worthy attempts to resolve the mushrooming complexities of medical socio-economics. Your Committee of 17 has spent hundreds of hours wrestling with crisis after crisis. The Relative Value Studies Committee has rendered yeoman service. The Workman's Compensation Committee has learned many a bitter lesson. Our Peer Review Committee has achieved national recognition for its unpalatable and arduous accomplishments.

At the FMA meeting last May, the House of Delegates approved the concept of a Health Data System in one county which might be used as a model for state-wide application. This action has spawned a great many questions:

1. What type of committee within the medical community will be formed (by county, hospital, medical society?).

2. What type of reviews will the committee be responsible for (Medical audit on individual patients, or length of stay comparisons by hospital or doctor?).

3. Are all M.D. and D.O. hospitals in the

county in the "project"? (It should be 100% for the statistics to be meaningful and the Utilization Review Committee to be effective).

4. Has the local medical society gone on record as approving and given great weight to participation by local physicians?

5. Are the local hospitals and/or medical society willing to contribute some amount toward the operation of a health data survey?

Information from Blue Shield-Blue Cross pinpoints the cost of the pilot project in Duval County in 1970 at \$46,775, or 41¢ per patient record abstract. Admittedly, this was a simplified type of PAS-HUP utilization study with accent on length of stay. All of the Jacksonville hospitals participated. Whether or not as a direct result of this experience, or in conjunction with the recent trend toward lower hospital utilization, the Riverside Hospital in 1971 found that their average length of stay had decreased approximately one day, even though the number of patients increased while the percentage of occupancy decreased.

If similar results could be obtained in all of Hillsborough County hospitals, it is estimated that savings of close to \$5-\$6 million in hospital costs might be achieved. State-wide savings are staggering to contemplate.

With the vast majority of costs covered by medical insurance, it is suggested that the expense of utilization review might well be taken from the premium dollar, which should be steadily decreasing as the savings become manifest. On the other hand, Paul Sanazaro, then director of NCHSRD, has suggested that "the costs of adequate review are to be determined as well as the respective share of those costs to be borne by the federal government, individual and institutional providers, private third parties or the paying patient," implying that the costs of review should be shared.<sup>3</sup> He also intimated that the National Center might create a health service data system by which to "evaluate and manage" the local system.

Obviously, the costs of peer review as covered by PSRO will be far higher than 41¢ per hospital chart. And just as clearly, Section 249F of H.R. 1 states "the Secretary [will] make payments to the [PSRO] organization equal to the amount of expenses reasonably and necessarily incurred as determined by the Secretary, by the organization in carrying out or preparing to carry out the duties and functions required by the agreement."

The Secretary was also granted powers to prescribe regulations to carry out provisions of the



law. As we have learned from Medicare, such regulations are usually unilateral and frequently have caused considerable consternation amongst providers and intermediaries.

Nevertheless, the law has clarified many questions regarding the breadth and extent of peer review. As stated, the professional activities in the area of *physicians* and other health care practitioners, and *institutions* and non-institutional providers are subject to review. Parenthetically, it should be pointed out that the PSRO law is concerned only with patients for whom payment, in whole or in part, can be made under the Social Security Act. Otherwise, it would seem review should also be directed toward health insurance companies since so many render substandard performance.

The primary intent of the PSRO law admittedly is cost containment—and the physician should accept this thrust of the federal charge with equanimity. He has much to offer as a strict professional and, if he does, the public has a great deal to benefit. The public and their political representatives have so far focused on physician charges, the visible portion of iceberg-like medical care costs. Hospital charges, the vastly larger hidden portion of the iceberg (now twice physician charges and steadily rising) will come in for closer scrutiny and accountability. Indiscriminate licensing, speculative financing, inordinate debt services, unrealistic accounting practices, unnecessary duplication of services, inappropriate use of progressive outpatient and self-care, inadequate ambulatory surgical and medical facilities, are just a few of the necessary changes that would substantially increase efficiency and lower costs.

Hospital charges have gone up primarily because hospitals have been able to absorb the costs—they have been able to absorb (and pass on) these costs, knowing that the money to meet the demand was available from insurance, Medicare and Medicaid, and other sources. Overuse of laboratory and x-ray facilities have likewise been accelerated by increasing malpractice awards. Reforms are long overdue.

Of considerable concern to many physicians by PSRO is the application of “recognized standards of health care.” These are to be professionally developed norms of care, diagnosis and treatment, on a regional basis, acceptable by the National Professional Standards Review Council (11 physicians of “distinguished” stature) and presumably to be developed with reasonable rapidity.

Fortunately, the concept of reasonable standards of care has been around for a long time. A brief historical review might alleviate unwarranted apprehension.

The first effective demand for systematic review and scientific evaluation of medical care, now termed “Medical Audit,” originated soon after 1910 as a result of the famous Flexner Report.<sup>4</sup> At that time there were some 165 medical schools graduating over 5,000 doctors annually, a majority of whom had not even high school qualifications before taking 24 to 30 months of medical “education,” that often consisted mainly of lectures and cramming for examinations with little or no laboratory and clinical work worthy of the name.

Lack of skills was giving medicine, and especially surgery, a bad name. Little improvement had occurred until Flexner’s painfully frank exposé was published. He did not mince words but gave names, dates and places, identifying “a wretched hospital, really a death trap, heavily laden with debt, and without laboratory equipment enough to make an ordinary clinical examination.” The constructive recommendations that accompanied this thorough exposure of bad conditions soon resulted in drastic reforms in medical education, the results of which are now history.

Thereby influenced, the Clinical Congress of Surgeons of North America in 1912 responded with the first organized expression of plans for comparable reforms in the quality of hospital care and surgical practice. Because of lack of financial support, its successor, the American College of Surgeons, faltered in implementing the plans, while with the millions of dollars received from the Rockefeller Foundation, old medical schools were improved or discarded and new ones established. Nevertheless, the ACS plan was that hospitals be judged individually according to objective measurements of performance, based on systematic analysis of cases.

With limited support from the Carnegie Foundation (1916—\$30,000, and 1920—\$75,000) the College conducted its first survey soon after World War I. It was an awesome task—2700 hospitals as compared to Flexner’s 165 medical schools. Further, a report severely critical of a hospital was bound to elicit a stout defense from doctors who as medical staff members depended upon it for their livelihood, such opposition far more vigorous than would be expected from the alumni of a censured medical school. It was known that only 89 of 692 hospitals with 100 beds or more were

able to meet reasonable standards, and it has been said that the facts disclosed by the survey were so shocking that the survey committee ordered the individual reports destroyed. The findings and the criteria employed were never published or even filed away. Instead, the College established minimum standards and expected the hospitals and doctors to set their own houses in order.

Another chapter in those early years of reform was written by a distinguished Boston surgeon, E. A. Codman,<sup>5</sup> who in his own hospital established objective measurements of performance based on a systematic analysis of cases. He also published an abstract of every case admitted in the years 1912 through 1916, classifying the results as favorable or unfavorable, and assigning responsibility for the latter to errors in diagnosis, inadequate technical ability, poor surgical judgment, improper care or equipment, and the type of disease or the patient's refusal of treatment. His system required also at least one re-evaluation of the case a year or more later, until a condition of stability permitting final judgment had been reached. Codman had widespread support for his system to be adopted by the College of Surgeons, but he was obviously too far in advance of his time and the more timid approach of hospital "standardization" replaced the "end-result" system.

In 1939 Ponton<sup>6</sup> attempted to revive the periodic analysis of carefully kept medical records by a system of "professional accounting" but met with little success. Neither did Ward, in 1947, who conducted a medical audit by employing quantitative methods.

The JCAH took over the field of hospital accreditation in 1952 and has subsequently revived interest in the medical audit. Paul Lembcke has provided us with a detailed account of these and succeeding developments of professional activity as an alternative to medical auditing.<sup>7</sup>

Beverly Payne continues the story<sup>8</sup> and outlines the evaluation of the Hospital Utilization Project (HUP) of Western Pennsylvania, Commission on Professional and Hospital Activities (PAS-MAP) in Michigan and the development of the Michigan Review Manual. Similar review guides have recently been published in Minnesota and Iowa, but in my judgment the Michigan study is the most adequate and definitive yet developed. Their scholarly manual was published in 1968 by the Department of Postgraduate Medicine of the University of Michigan Medical School—a prod-

uct of over 60 Michigan physicians with criteria for 135 I.C.D.A. diagnostic classifications and 22 operative procedures. It instructs in the use of such criteria for measuring diagnostic norms, quality of care and effectiveness of hospital use. While representing views of 1966, we could all benefit by studying its format and having it revised by Florida physicians for application to our own region's review process.

It must be recognized and stressed that the driving force behind the application of such methodology is an educational, self-evaluative goal. In all similar review efforts, there has been a conscious avoidance of punitive activity or individualization of criticism.

Does this bring us up to date on history? Not quite.

This past November, Sanazaro reports on the Experimental Review Care Organization Program, originally discussed at the 1971 Health Conference of the New York Academy of Medicine<sup>9</sup> where he described the establishment of a small number of Experimental Health Services Planning and Delivery Systems under the auspices of the Health Services and Mental Health Administration (HSMHA), which he then headed. These are described as "carefully selected laboratories for determining the extent to which we can achieve the benefits of system properties in health services while retaining our pluralistic approach." More equitable access, cost moderation and maintenance of quality of care were primary objectives.

Utilizing data systems studies in Hawaii, methods were developed for assessing objectively the content of office and hospital care. Ten EMCROs (Experimental Medical Care Review Organizations) have been funded with "the stated purpose of systematic analysis of the content of medical care being given to patients in hospitals, offices, clinics, extended care units and skilled nursing homes." Involved are some 8,000 physicians serving approximately 4 million patients, primarily Title XIX (Medicaid) beneficiaries. It is modeled on methods used by the San Joaquin Foundation for reviewing office care and those of the Professional Activity Study (PAS) in establishing systems for collecting and summarizing data on hospital care. Data obtained from these reviews are planned to be used in designing local programs of continuing medical education in cooperation with medical associations (Georgia, Pennsylvania, Hawaii), *state hospital associations* (Mississippi), *Regional Medical Programs* (Missouri, Utah,



Pennsylvania, Georgia, Oregon, Hawaii), *insurance companies* (Travelers, Blue Cross, Blue Shield), *state health departments* (New Mexico, Virginia) and so forth. These are expected to evolve into PSRO-like bodies carrying on comprehensive and objective quality assessment and "providing a new order of public accountability in medical care."

In Chicago, eleven years ago, the AMA's Council on Medical Services, the American Hospital Association, Blue Cross Association and the National Association of Blue Shield Plans held a conference on utilization review and charged the participants to go back to their states and find the answers. These same groups held a similar conference 10 years later and agreed "Everybody's doing something but we all have a long way to go." Workshops at last year's meeting recommended:<sup>10</sup>

1. Dominant roles must be played by the respective national organizations to take the message to lagging component groups and present a unified front.

2. There should be improved communication and regular meetings on cost containment between the various state medical and hospital groups and the Blues. (To this must be added all qualified carriers.)

3. The medical profession should provide parameters of medical practice which the Blues (and, again, other carriers) can apply in their operating systems.

4. (And most important) The Blues' data bases should be reorganized and expanded to make them more useful to medical review.

5. Specialty societies must play an active role. The ultimate purpose of review, it was agreed, is to benefit the patient. Might there not also be a hidden benefit for the physician?

A constantly reappearing theme in the review story is self-evaluation, self-improvement and continuing educational goals rather than punitive aspects. This refrain began in 1910 and is repeated right into the PSRO law. It harmonizes completely with quality delivery of care. The basic tune is the establishment of criteria for good medical care management. Constantly emphasized is that, in most instances, these should be determined at the local or state level by the practicing physician. The process of setting practice criteria and developing a data display of actual performance is a valuable educational experience requiring specific responses of learning processes in order to correct shortcomings and narrow the gap between optimal model and actual performance.

Barber Mueller has contended that usual examinations are inappropriate methods for continued assessment of physicians in practice and that it is a physician's performance at work in a responsible setting that must be evaluated.<sup>11</sup> He recommends a system analyzing the processes of patient management and the results of patients managed. Such a system (as does PSRO) requires a permanent register of procedures and effectiveness to be found in office records, hospital admissions, operative records, tissue reports, medical audits, hospital-stay data, complications, diagnoses, deaths, etc.—a veritable host of objective data, not only for optimum review but for ongoing and continuing medical education. The accumulation, processing, storage and retrieval of massive bits of data has now become a medical necessity.

Sophisticated machinery for data processing has been used by Blue Cross-Blue Shield for years; and record room review has been conducted by the Commission on Professional and Hospital Activities for almost two decades with vast computer commitments in the past 10 years to implement their PAS-MAP program in over 1400 hospitals. HUP likewise has a similar capability. A major decision for us in Florida is whose computers and what programming do we use? What do we do at the local level?

I think it quite obvious by now that physicians in all major counties will have to quickly develop new organizations. These, it appears, should include doctors of osteopathy. Since the PSRO act requires at the state level a "Statewide Professional Review Council" to include a representative from each PSRO, two designated by the FMA and two by the FHA, plus four public representatives who may or may not be physicians, it is only commonsense to include in local PSRO units selected representatives of other providers, hospitals and consumers. The law specifically states that only the physician will be responsible for review activity. Also, he must be a member of the active staff of a hospital. The other members are to assure public accountability as well as to provide advice and, hopefully, liaison with hospitals, carriers and patients.

The organization should likely be structured as a medical Foundation or Institute representing a group of counties or county or portion thereof. The FMA ought to establish a similar organization so as to advise and coordinate local activities and probably to negotiate for a data bank as well as develop a working relationship with the state-

wide PSRO Council. Whether doctors as hospital staff members will become the major influence on PSROs (stated American Hospital Association goal with their Quality Assurance Program [QAP] for Medical Care) or whether physician members in Foundations establish that priority, remains to be seen. It likely depends on whether organized medicine meets the challenge, although confining the review process initially to hospitalized patients would seemingly favor hospital medical staff (under jurisdiction of Boards of Trustees) ascendancy. On the other hand, we may well see insurmountable conflicts of interest in this regard since the hospital staff is no longer master of its ship but under increasing regulation and control by the hospital Board of Trustees (Darling and subsequent legal decisions). Let us hope the president of the AMA, Dr. C. A. Hoffman, is correct in forecasting a "community of interest rather than a fight over PSRO control."<sup>12</sup> Nonetheless, we must *maintain absolute safeguards* that our *physician colleague in practice* is our sole judge and peer—NOT health departments, hospital associations, insurance companies or Regional Medical Programs. (EMCRO vide supra).

At its last meeting, the Pennsylvania Medical Society activated the Pennsylvania Medical Care Foundation. Likewise, on December 10, 1972, after rejecting a proposal calling for formation of a medical union, the Medical Society of New Jersey voted, at a special House of Delegates meeting, for creation of the Medical Society of New Jersey Foundation for Health Care Evaluation with board members composed not only of physicians but also representatives of hospitals, labor, management, consumers, health insurance industry, state planning agencies and prepaid health service plans.<sup>13</sup>

In the past two decades we have seen the public embrace the insurance mechanism as the preferred system for meeting health care expenses. Predictability of costs is universally recognized (but not always by physicians) as the most important factor in estimating the insurance premium. One simply cannot take more out of the pot than is put in. Consequently, physician charges and fees are a direct concern to the public and to medical insurers (vendors, third-party payors, fiscal intermediaries, etc.).

Predictability demands fee schedules—it's that simple. Whether we call them usual, customary, reasonable, prevailing, average, or what have you, it's all the same. Eventually, these become fixed

fee schedules and we are going to have to learn how to live with them. One such way is for us to support the Relative Value Studies and to negotiate *yearly* conversion factors which in essence would give us a variable fee schedule. Another is to maintain our right to enter into prior agreements with patients regarding the fee for services to be rendered—this excludes the insurance carrier from liability for the difference. At the same time, we must insist that the difference not be called excessive or unreasonable.

Dual fee schedules should be forgotten. There is no place for dual standards of care morally or legally and therefore there cannot be a valid argument for different charges by specialists as opposed to generalists for similar services. Frank and honest peer review can resolve all of these problem areas, but unless guided academically and administratively by FMA, it is doubtful there would be widespread cooperation and endorsement by our membership. Procrastination will undoubtedly bring on self-proclaimed experts to lead us to light and salvation and to their own personal and political advancement. We need all the leadership Florida Medicine can muster—now.

"There is," said an ancient philosopher, "nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in a new order of things." We will have to exert every effort to lead, to bend, to reason, and to maintain our cool. By bringing the public into our deliberations and always acting as professionals, we may well be able to maintain their trust. As so well stated by Vannevar Bush, "If democracy bears down harshly and unjustly on the independence of a professional minority, it will strike at the roots of its own being."<sup>14</sup>

The term "professional" has been used repeatedly by the writers of the bill. This obviously refers to the physician provider and indicates they consider us professionals.

The difference between business and commercial endeavors as opposed to professional services, and the major distinguishment as trust for the professional, is forthrightly outlined by the distinguished editor of the *New England Journal of Medicine* in an editorial entitled, "Why Trust The Professional."<sup>15</sup> I believe it is particularly apropos at this time since the bill also concerns itself with conflicts of interest. Strict commitment to an honored and traditional Code of Ethics gives us a last ditch opportunity to provide leadership and to set examples within the Review frame-



work which could materially recoup and enhance public confidence and support.

I am convinced that medical review, properly managed at the local and state levels, in the long run may well be the turning point in the struggle to retain private fee-for-service practice as the best system for medical and health care.

#### Abbreviations Used

PSRO	Professional Standards Review Organization
HMO	Health Maintenance Organization
EMCRO	Experimental Medical Care Review Organization
NCHSRD	National Center for Health Services Research & Development
JCAH	Joint Commission on Accreditation of Hospitals
HUP	Hospital Utilization Project of Western Pennsylvania
PAS-MAP	Professional Activity Study, Medical Audit Program (Commission on Professional and Hospital Activities, Ann Arbor, Michigan)

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► Dr. Essrig, 13 Davis Boulevard, Tampa 33606.

More than 1,300 persons have died from narcotics abuse in New York City this year, that city's chief deputy medical examiner told a conference on the "Medical Complications of Drug Abuse" sponsored in Washington by the AMA's Committee on Alcoholism and Drug Dependence.

Michael M. Baden, M.D., said that heroin addiction has become the leading cause of death among persons between the ages of 15 and 35 in New York. At the same time, more than 30 per cent of narcotic deaths in the city have been associated with methadone use—both legal and illegal, Dr. Baden said.

Methadone will be distributed only through hospital pharmacies, approved maintenance programs, and certain drug stores in rural areas, under newly tightened regulations announced by the Food and Drug Administration. The new restrictions are necessary to curb "a growing problem of abuse and diversion of methadone," said FDA.

Effective immediately, FDA is requiring patients to have been addicted to heroin at least two years before participating in a methadone-maintenance program. Enrollment of minors will be limited. Patients 16 to 18 may remain in current programs, FDA said, but no additional minors may be admitted unless a consent form is signed by a parent, legal guardian, or a state-designated authority.

The new rules require patients of treatment centers to take the drug daily at the center, under observation, for the first three months. If they show satisfactory progress, they will be allowed to take home two-day supplies, and after two years, three-day supplies.

J. Willis Hurst, M.D., recent past president of the American Heart Association, told the conference that a preliminary survey indicates that drug abusers' contaminated needles are now one of the leading causes of bacterial endocarditis in the nation.

# The Community's Disaster Plan

CLAUDIUS J. WALKER, MSPH AND BENJAMIN A. JOHNSON, M.D.

Planning against the ravages of disaster makes good sense and the medical community, including its physician population, is essential in developing these plans, in participation, testing and evaluation of the end results. The physician should initiate the planning effort for eventually he and the other members of the medical community must render treatment. It is to their advantage that prompt and proper emergency medical care be available so as to maximize survival and minimize injuries.

The Division of Health, Department of Health and Rehabilitative Services, in conjunction with the community director of civil defense, offers assistance in developing disaster plans. Numerous communities have taken advantage of this program and their plans have withstood practical demonstrations.

## Functional Elements

The plan must include the various functional elements found in any emergency medical system. A most important one is communications. Two fairly recent events illustrate the role of this element.

The explosion at the Thiokol Plant near Woodbine, Ga., illustrates the confusion resulting from loss of normal communications. The explosion wrecked the main plant telephone system but did leave one phone operational at the gate two miles away. This one was used to call the Camden County (Georgia) Sheriff's Office and Gilman Hospital in St. Mary's, Ga., alerting them to the imminent arrival of an unknown number of casualties. For some reason that telephone was not used again. The Gilman Hospital administrator called Duval Medical Center in Jacksonville, then the telephone at that Hospital became useless due to incoming calls.

The Camden County Sheriff's Office requested rescue vehicles from the Nassau County (Florida) Sheriff's Office which in turn informed the Fernan-

dina Fire Department. Several more messages were received by the Nassau County Sheriff's Office from the Charlton County Sheriff's Office and from the St. Mary's City Police Department. One call asked for physicians and pain killers. It was relayed to the Jacksonville Police Department then on to the Jacksonville Fire-Rescue Service which sent two units with supplies, a chief's car with four physicians and more supplies from Duval Medical Center. The last vehicle was en route in 15 minutes or less. The Rescue Service received the call 52 minutes after the explosion; the last living casualty had been removed from the scene some 12 minutes previously.

The communication system worked; messages were transmitted but these were nonspecific. Aid was dispatched and some was effective, but well-intentioned efforts created obstacles to evacuation. For instance, a two mile traffic jam blocked the only access road to the plant.

The smaller disaster occurred in Monroe County. At 1:05 a.m. young Abel Jeter was accidentally shot in the head at Islamorada, Florida. An ambulance and a sheriff's patrol car answered the distress call. At first, existing communications were used intelligently, then for reasons unknown, they were not used. Finally communications came back into play and treatment for the boy was accomplished. What should have been a 62-mile ambulance run became a 234-mile agonizing tale of errors. The highway patrolman on duty near Tavernier was the first to answer the call for help. He was joined by the fire department ambulance and volunteers. They called a small privately-owned community hospital, three miles from the motel, but a nurse on duty told them that there was no doctor to treat the boy there. At 1:30 a.m. the ambulance started for Fishermen's Hospital in Marathon. Enroute, radio calls to the squad car relayed information that Fishermen's Hospital would not accept the boy because no one was available to treat him. The hospital informant



recommended that the vehicles continue on to Key West where a neurosurgeon would be waiting at Monroe General Hospital. In Marathon, at 2:05 a.m., an hour after the accident, young Abel and the oxygen equipment was transferred to a faster squad car. Reaching Monroe General, in Key West, it was learned that information relayed from Fishermen's Hospital was wrong. No neurosurgeon was waiting. There was no neurosurgeon in the entire Keys. The Jeters, who had followed the ambulance in their own car, then telephoned a widely known Iowa neurosurgeon who visits Islamorada. From his home in Des Moines, he suggested emergency treatment and recommended a Miami neurosurgeon who was then contacted. The still unconscious boy was placed back in the ambulance and at 4:10 a.m. left for a 145-mile dash to the South Miami hospital, pulling into the emergency entrance an hour and 50 minutes later. At 7:00 a.m. the boy was wheeled into the operating room. At 1:30 he was in the recovery room and the doctors pronounced the surgery a success.

### Similar Patterns

As the examples illustrate disasters are not alike but similarities exist. A stadium collapse or a hotel fire will present different problems but the pattern in dealing with them is similar. First, the disaster is discovered. Injured individuals are a primary constant. The disaster is reported to the fire or police department or ambulance service. The victims must be extricated and given first aid. They are transported to a medical care facility and given proper medical treatment.

The medical community deals not with the disaster but with the survivors. The stadium collapse may require use of heavy equipment to remove beams to enable extrication of victims and will probably present the hospital with many fractures. The fire will require ladders and smoke masks to enable rescue and present the hospital with a number of victims suffering from smoke inhalation.

Neighboring communities, state and federal government will send assistance to the community but it will arrive late. Initially the disaster is the sole responsibility of the survivors. Finding local assistance is not difficult. Medical care exists in every community. It begins at the scene and ends at the hospital or morgue. The quality of this care depends upon training. Unless training has been

effective, the initial care can do harm as well as good. A simple fracture is easily converted to a compound fracture by hurried, frantic handling. The existing communications systems should be utilized through prior arrangement and planning to marshal the community's existing resources.

All agencies that deal with the day-to-day emergency situations have a plan to handle disasters. This includes the police, fire department and hospitals. Civil defense and its delegate agencies have been planning and revising plans for almost any eventuality since 1952. Therefore, the problems that arise when a disaster occurs is because there has been a lack of coordination among agencies which have made these plans. Major, of course, is the absence of any system of automatic notification. Generally, most plans deal only with the agency and the original report of the disaster. Seldom is the hospital notified of the incoming victims simply because it is assumed that the hospitals are always ready for every situation. Unfortunately the hospitals are also the last to be notified when the disaster situation has ceased.

### Staging

Mock disasters can be realistically staged. Later the actions of each agency are discussed. Whatever is done improperly or which has not been done is modified or arrangements made so that it will be done the second time. A second drill utilizing a different type disaster is held after a few months to test the effectiveness of the changes. Eventually the community evolves the plan which will cope with the real disasters. Once the community has coordinated its own resources, the incorporation of outside help can then be made by mutual arrangements.

The film, "A Date With Disaster," produced by the Office of Emergency Preparedness is a valuable asset in arousing interest and guiding community planning and training. Assistance can be obtained through the county health director or the civil defense director. The Division of Health will assist in any of these procedures.

The initiative, however, must come from the community. The physician can be the pivotal factor for success or failure of this effort. After all, disaster planning is nothing more than the practice of preventive medicine.

► Dr. Johnson, P. O. Box 210, Jacksonville 32201.

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# MEETINGS

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Meetings Held in Florida

## MARCH

- 19-22 Controversial Issues in Pediatric Cardiology, Sonesta Beach Hotel, Key Biscayne. For information: Sidney Blumenthal, M.D., P.O. Box 875, Biscayne Annex, Miami 33152.
- 26-31 Selected Topics in Genitourinary Roentgenology, Playboy Plaza Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.
- 26-31 Practical Management and Therapy of Neurologic Disorders, Department of Neurology, University of Miami School of Medicine, Miami. For information: Division of Continuing Education, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

## APRIL

- 16-21 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.
- 27-29 A Workshop on the Diagnosis and Treatment of Childhood Cancer, University of Florida, Gainesville 32601. For information: Charlene Taft, Div. of Continuing Education, University of Florida, Box 758, Gainesville 32601.

## MAY

- 28-30 Fourth Annual Topics in Internal Medicine, University of Florida College of Medicine, Gainesville. For information: Charlene Taft, Div. of Continuing Education, Box 758, Gainesville 32601. (Dates changed from May 9-11).
- 29-31 Master Interpretation of Clinical Electrophysiology, Contemporary Hotel, Disney World, Lake Buena Vista, Florida. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## MAY

- 3- 5 Association of Clinical Scientists, Hawaiian Village, Tampa. For information: F. William Sunderman Jr., M.D., University of Connecticut School of Medicine, Drawer B., Newington 06111.
- 3- 7 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. For information: Robert D. Reinecke, M.D., Albany Medical College, Albany, N. Y. 12208.
- 6-12 American Society for Microbiology, Fontainebleau Hotel, Miami Beach. For information: Mr. R. W. Sarber, 1913 I St., N.W., Washington, D. C. 20006.
- 12-14 American Association of Blue Shield Plans, Diplomat Hotel, Hollywood, Fla. For information: Jean A. Borger, 211 E. Chicago Ave., Chicago 60611.
- 21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

## JUNE

- 11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

## OCTOBER

- 21-25 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Miami Beach. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

## NOVEMBER

- 8-10 Gerontological Society, Deauville Hotel, Miami Beach. Exec. Dir.: Mr. Edwin Kasowitz, 1 Dupont Circle, Washington, D.C. 20036.
- 11-16 American Association of Blood Banks, Americana Hotel, Miami Beach. Central Office Manager: Miss Lois J. James, 30 North Michigan Avenue, Chicago 60602.



## Editorials

### PSRO—The Ultimate Challenge to Our Profession

It was my privilege to preview "Medical Review-Friend or Foe," by I. M. Essrig, M.D. prior to its publication in this issue of the FMA Journal. Dr. Essrig has thoroughly covered the History of Review Activities and his recommendations for implementing the law should be a challenge to all physicians.

Having served as chairman for your Peer Utilization Review Committee for the past three years, I view PSRO as the ultimate challenge to our profession. When we accept it, as we must, and put into action the administrative leadership necessary to move forward, then and only then can we hope to see the medical profession held once again in the esteem to which we have been accustomed.

We must realize that PSRO creates a "New Deal" for medicine and the government is doing the dealing. The public has come to regard health care as a RIGHT and they expect quality care at reasonable cost. To assure these expectations Congress has legislated participation at the policy-making level.

While we may differ on the methods, the procedures and even the expected results, the theme is evident. It is too late to reminisce about the "Good Old Days" and what should have been done, rather, its time to focus on the future. Bureaucratic rules and regulations, public account-

ability and multiple review ideas foreshadow difficult times, but if Florida Medicine is to take the lead it must act NOW.

PSRO is the LAW and its implementation is our most important and immediate problem. While questions of how and what must still be evaluated, the basic structure can and should be implemented. Carrying the PSRO concept through to an effective nationwide system constitutes the ultimate challenge.

This requires very careful inter-relation among physicians, health care institutions, carriers, intermediaries and government payment programs. Ideally, the PSRO function can be extended to encompass patients under non-governmental coverage. The PSRO system, assuming we can establish it effectively, will be fundamental to any form of national health insurance.

What should we do in Florida? Ignore the law and await the ax or continue as we have been with force, vigor and leadership! FMA has organized, developed and operated the most effective, the most comprehensive and the most honorable system in the United States. If I sound prejudiced it's because I am. I've had the privilege of working with some of Florida's most qualified, conscientious and dedicated physicians and, as I stated recently at the FMA Leadership Conference in Orlando, they should be named to AMA's Hall of Fame. These men are both willing and capable of undertaking any new review programs and their expertise is invaluable.

Dr. Byrne is Chairman of the FMA Peer Utilization Review Committee.



Florida is in the unique position of being able to literally write the rules by establishing the required State Review Council and State Advisory Group. We can designate our own PSRO areas and assist these areas in organizing and operating as PSRO units.

Existing Peer Review, Utilization Review and Insurance Review committees can be utilized as the nucleus of the local PSRO's. Local organizations, staffing, and programs, in general, should be similar but latitude for local conditions should be allowed. Mechanisms, data programs, etc. can be worked out *after* these structures are established.

With cooperation and understanding, we will remain the leader. We can designate our own

PSRO areas and be fully operational before the government devises a system. OUR regulations, rules and procedures can be an example to other states and to the government. Unless they can devise a "better way," Florida will be calling the shots, not waiting for outside direction.

PSRO is fact! We know the intent of the law and hopefully we understand the need. Doctors are interested, some are experienced, and hopefully ALL will be ready and willing to participate. A new Era of Medicine is beginning and Florida has the opportunity to lead. What a challenge. . . . .

JAMES B. BYRNE, M.D.

► 6790 S. W. 67th Street, Miami 33143.

## Thoughts on a Disaster

During the recent holiday, a commercial airliner crashed near Miami with an immediate loss of about 80 lives among passengers and crew. This qualifies as a "disaster" and will be so catalogued by the appropriate officials.

Disappearance of the aircraft from Miami International Airport traffic control screens plus eyewitness accounts of the impact flash triggered recognition and detection of the incident. The shock was duly transmitted via various communication pathways to agencies directly involved: airline officials, Air Force, Coast Guard, fire, police and Highway Patrol. Since the incident occurred near midnight, personnel involved were shift commanders of the Air Force, Coast Guard, fire and police, and similar "on duty" staff of other agencies such as hospitals.

On impact occupants of the aircraft were either alive or dead and, further, easy or difficult to locate among the debris. Activity of medical personnel useful to those surviving can be divided into that at the scene and in the receiving hospitals. In this incident the scene may be divided into the actual crash site—sawgrass swamp six

inches to four feet deep in water and muck—and the nearest dry ground, a secondary road 200 yards from the nearest part of the crash site.

Only a small number of medical personnel should have been at the crash site to perform the critical interventions: IV's, resuscitative or support drug administration, endotracheal intubations, and other potentially lifesaving measures. Skilled paramedics could have shifted most victims to the road (call it the command post or triage point) where the bulk of site medical personnel with supplies, lights, and means of communication with available authority could have readied patients for transport, assessing priority and destination.

The total number of medical personnel needed usually is small but those with experience and authority are highly desirable. They are qualified to provide the hospitals with an estimate of the number and type of injuries so that emergency measures may be escalated or shut down. Obviously the bulk of medical personnel should be at the receiving hospitals.

Inexperience with disaster or emergency measures often leads to extremes such as (1) over or inappropriate treatment (an obvious example is treatment with narcotics at the scene, risking hypotension and/or shock, vomiting and aspiration, or apnea and cardiac arrest) and (2) undertreatment (usually manifested by yelling for the paramedics to "get them to the hospital now" without determined attempts to assess severity of injury or necessity for critical intervention.)

In the aftermath of this particular incident, there was general public acceptance of the emergency medical measures. This opinion is deserved. The experience, however, provokes serious thought not only by the aircraft industry but our own profession as well. Were unconscious victims with nonlethal injuries drowned or ambulatory victims similarly lost? Were survivors who later died in

hospitals capable of salvage by earlier definitive treatment at the scene or during transport?

The lessons to any community are clear. Disaster medicine seldom can be taught, but it may be learned by experience provided one is open to critical discussion. The frequency of such occurrences is fortunately low, but visibility is correspondingly high. Few participants wish to criticize their personal efforts but are quick to comment on those of others. Probably one of the classical descriptions of such an event is worth mentioning.<sup>1</sup> Few of us possess such honesty and accuracy for detail as does Dr. Shaftan. If we did, our medical preparedness for disasters would be immeasurably strengthened.

1. Shaftan, G. W.: Disaster and Medical Care, J. Trauma 2:111-116 (March), 1962.

E.L.N.

## Emergency Medicine

Calamities which produce confusion, pain and anguish lead an endless list of indignities heaped upon those whose cry for help goes unanswered. Too often such an experience follows being forced to accept help from ill-mannered medical personnel with lack of compassion, but also can arise through neglect or from attention by those not having had proper training. With a growing concern for the outrages heaped upon man by an ever increasing number of physical and mental onslaughts, emergency room physicians are looking for a method to relieve such affronts. Seeking a means to characterize this modern specialty and its new disciples, they are searching for a name. "Emergentologists" with linguistic grafting could become "Emergiatrician," or shortened, "Emergician." "Franticologist" connotes the frenzied frenetic activity in some ER's, while the need for critical care is expressed by "Criticologist." The primary care so often sought implies "Primatol-

ogist" but the nature of many patient complaints is better indicated by "Traumatologist."

All this and more appeared in a recent issue of the Journal of the American College of Emergency Physicians, where culled from Greek mythology, the Goddess Tyche, one of the fates, a daughter of Zeus, emerged as the local guardian of the luck of a city. Recognizing in the cult of Tyche a promise of relief from man's helplessness, coined is the word "Tychology" or "Tychologist" to provide in one name the means to characterize this modern specialty. Aspiring to recognition among their colleagues, physicians in emergency medicine, responsive to patients and their pressing needs are concerned with the immediate relief of suffering and the proper treatment of each patient's condition. No matter by what name they go, having at heart these traits, they shall be called blessed.

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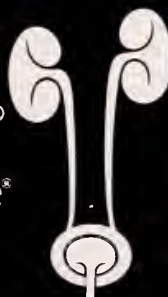
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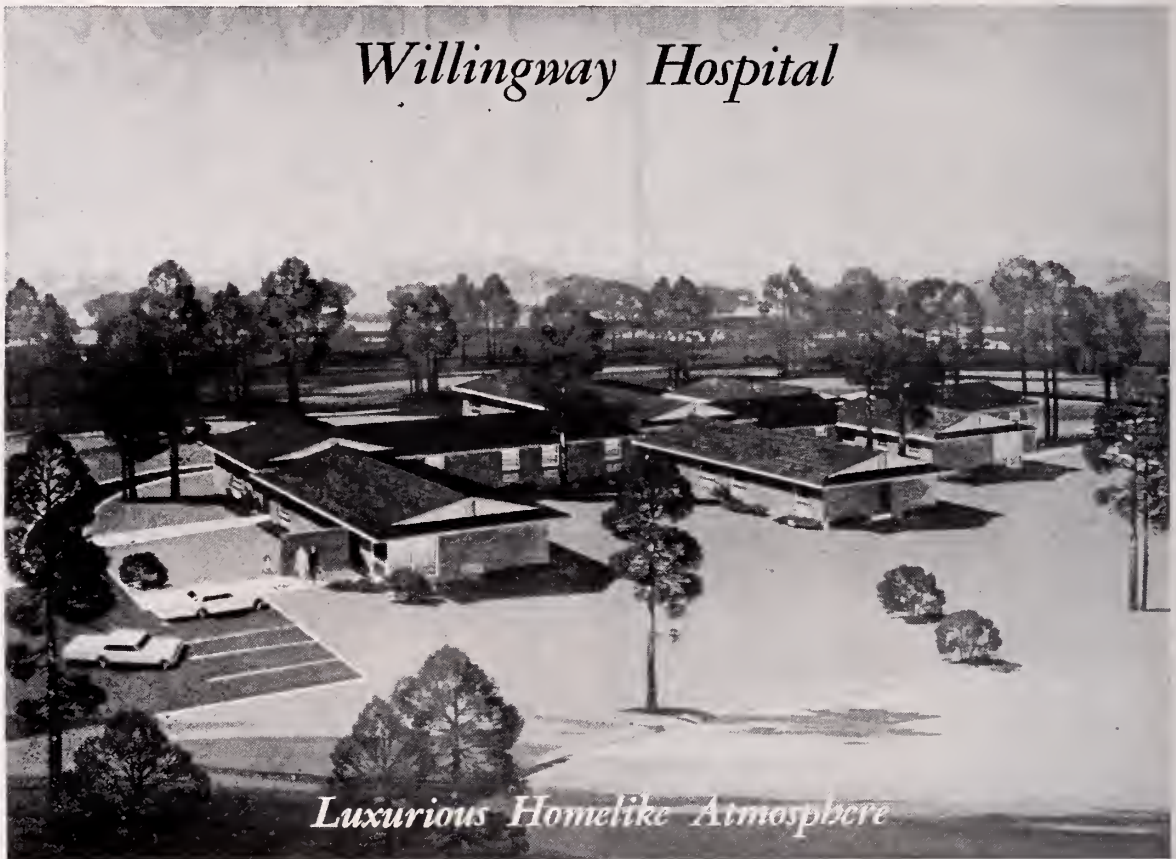
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## ORGANIZATION

# Fifteenth Annual FMA Leadership Conference and Seminar on Medical Legislation January 27-28, 1973

The national health insurance debate may have a relatively happy ending for medicine, the Executive Vice President of the American Medical Association told a FMA sponsored conference. Ernest B. Howard, M.D., predicting that federal intervention in the health care field will increase over the next decade, does not foresee a health care system as advocated by Sen. Edward M. Kennedy and organized labor but thinks PSRO development will be slow until someone in the Department of HEW is appointed to head up the program.

"I believe we will survive with a maximum degree of freedom, provided we act with reasonable statesmanship," he told the Fifteenth Annual FMA Leadership Conference in Orlando on January 27. Dr. Howard's observations on "The National Medical Scene" have become a traditional feature of the conference.

Registration for the Conference and the Seminar on Medical Legislation which followed on January 28 totaled 155 county medical society officers, representing 95 per cent of the membership of the Florida Medical Association. Highlighting the sessions were lovely Catherine DeVito and Mary Ann Mathews, president and president-elect, of FMA's Woman's Auxiliary. They described their Health Education Conference planned for March 15 and 16 at St. Petersburg where they hope to teach the public to assume responsibility for their own health.

William J. Dean, M.D., FMA President, conducted the morning program like a veteran. Joseph C. Von Thron, M.D., President-Elect, presided at the afternoon sessions and kept the audience awake with his witty commentaries, but

met his match in Byron Thames, who bested Joe with a long story which left him with nothing but his socks. John C. Fletcher, M.D., Vice President, ran Sunday's legislative seminar smoothly.

The Hon. Emmett Roberts, Secretary of Florida's Department of Health and Rehabilitative Services, at the outset of an address that covered a variety of subjects of concern to medicine, stated that there will always be an open door between his agency and the FMA. He complimented Florida physicians for their activities in the war on drug abuse and in the establishment of areawide health planning councils, to which the department will look for advice more and more in the future. Suggesting that some of the inequities in the Medicaid program might be eliminated or at least lessened, but because Washington is insisting on more accountability in the expenditure of medical funds, he foresees no possibility of "detailed change" in "prior authorization". Efforts, however, are being made to simplify that requirement.

On other topics, Mr. Roberts said:

—He is seeking, in his budget request, establishment of a position of "medical services coordinator" to oversee medical services dispensed by all divisions in his vast agency.

—The new budget contains more funds for county health departments.

—The kidney disease program is now operational and has been transferred to the Division of Health.

—He does not favor creation of additional health-related divisions in HRS at the present time because it "would splinter his department and create havoc."





(Top left to right) A. D. Thaeler, M.D., President, Clay County Medical Society; Richard C. Dever, M.D., Member, FMA Board of Governors; M. E. Groover, M.D., President, Nassau County Medical Society; Thomas S. Edwards, M.D., Past President FLAMPAC; W. Dean Steward, M.D., Past President FMA; James T. Cook, M.D., FMA Past President, Temporary President, Florida Physicians Association and AMA Alternate Delegate; George A. Dell, M.D., President, Alachua County Medical Society; Mrs. Arnold J. Spanjers, Past President WA/FMA; Mrs. William H. Mathews, President-Elect, WA FMA; Franklin J. Evans, M.D., FMA Speaker of the House; Jack A. MacCris, M.D., Member, FMA Board of Governors; J. N. Carlson, M.D., President, Sarasota County Medical Society; Thomas B. Thames, M.D., Chairman, Council on Medical Services; D. C. Allbritton, M.D., President, Marion County Medical Society; O. W. Davenport, M.D., President, Dade County Medical Association; T. J. Marshall, M.D., President, Escambia Medical Society; T. H. Nichols, M.D., President, Lake County Medical Society; A. S. Capi M.D., President, Broward County Medical Association; Hon. Emmett Roberts, Secretary of Florida Department of Health and Rehabilitative Services; W. Harold Parham, FMA Executive Vice President; William M. C. Wilhoit, M.D., Member, FMA Board of Governors; Joseph C. Von Thron, M.D., President-Elect, FMA; David C. Lane, M.D., Senator from 31st District; William J. Dean, M.D., FMA President.





(Top left to right) John H. Parker, M.D., President, Taylor County Medical Society; Howard Dubose, M.D., President, Polk County Medical Association; W. E. Marry Jr., M.D., President-Elect, Polk County Medical Association; Burns A. Dobbins, M.D., Member, FMA Board of Governors and AMA Delegate; Frank C. Coleman, M.D., AMA Alternate Delegate; James W. Walker, M.D., FMA Secretary and Treasurer; R. E. Allison, M.D., President, St. Lucie-Okeechobee-Martin County Medical Society; Philip B. Phillips, M.D., Vice Chairman, Council on Legislation and Public Agencies; Louis C. Murray, M.D., FMA Vice Speaker and Chairman, Committee on National Legislation; F. B. McKechnie, M.D., Secretary, Orange County Medical Society; Victor H. Knight, M.D., President, Hillsborough County Medical Association; Frederick C. Andrews, M.D., Chairman, Council on Specialty Medicine; R. C. White, M.D., President, Manatee County Medical Society; Vincent P. Corso, M.D., Chairman, FMA Judicial Council; John A. Rush, M.D., President, Duval County Medical Society; Irving M. Essrig, M.D., Member, FMA Board of Governors; James L. Borland Jr., M.D., Chairman, Subcommittee on Foundations for Medical Care, and Vice President, Duval County Medical Society; Ernest B. Howard, M.D., Executive Vice President, AMA; James B. Byrne, M.D., Chairman, Committee on Peer Medical Utilization Review; Jere W. Annis, M.D., FMA Past President and Member, AMA Board of Trustees; and Jack Q. Cleveland, M.D., FMA Past President and AMA Alternate Delegate. Photographs by courtesy of John W. Glotfelty, M.D., of Lakeland.



—The Division of Health has personnel and sophisticated laboratory techniques which might be utilized in the event the legislature provides funds for a sickle cell anemia program.

Louis C. Murray, M.D., of Orlando, a member of the FMA Council on Legislation and Public Agencies, began the morning with a discussion of the Association's 1973 state legislative program by listing the following priority items: (1) revision of Florida's Medicaid program; (2) exemption of records of medical society and hospital review committees from court subpoena; (3) defeat of legislation forcing health insurance companies to cover chiropractic services, and (4) reorganization of health-related functions of state government.

James B. Byrne, Chairman of the Committee on Peer Medical Utilization Review described the Professional Standards Review Organization (PSRO) provision of HR 1, giving a frightening glimpse of possible future governmental control of our practices. He related his own personal ideas as to how FMA might participate in this massive project which is reprinted elsewhere in this issue of the Journal. "The government is in turmoil over PSRO," Dr. Byrne observed. "No one knows what is going on, for most of the M.D.'s in ranking federal positions have submitted their resignations or have left."

Jim Borland, whose name appeared on the program above Dr. Byrne's, was asked to follow Dr. Byrne, so he proceeded to upstage his colleague by falling off the platform, astride his chair, as calm and cool as if he were on skis. After arousing applause he proceeded to listen patiently during Dr. Byrne's presentation. Concluding the facts on how to develop a foundation for organized medicine's response to PSROs, he kicked the replaced uprighted chair off the platform and sat down in one not so close to the edge. Dr. Borland spoke of what can be done locally to prepare for PSRO, by forming a very flexible organization—the foundation for medical care which might be accepted by the Department of HEW as local PSRO mechanisms.

Vincent P. Corso, M.D., Chairman of the Judicial Council, described the quarterly two day meetings of his Council, including the current series of regional membership, discipline and ethics conferences. The Council is in the process of surveying county medical society customs to determine whether they would favor the promulgations of statewide standards on newspaper advertising and telephone book listings by the Council. The

Judicial Council Chairman urged county medical societies to do what they can to have appeal mechanisms built into medical staff by-laws for the benefit of physicians dismissed from their hospital staffs.

Franklin J. Evans, M.D., Speaker of the FMA House of Delegates and an attorney as well, spoke of the close relationship between medical ethics and the law. Many situations and acts are prohibited by both ethics and the law, he said, and unwarranted criticism by one physician of the work of another is a major cause of medical malpractice suits. Medicine must "weed out those who are bringing discredit upon the profession," he concluded.

Opening the afternoon session was Thomas B. Thames, M.D., of Orlando, Chairman of the Council on Medical Services, who discussed the National Health Service Corps program which places physicians, dentists and other personnel in areas of health manpower shortages. Dr. Thames stated it is necessary for county medical societies to endorse an application before these physicians can enter any area.

James T. Cook, M.D., Temporary President of the Florida Physicians Association, Inc. explained what FPA can do and what it cannot do. A Board of Directors soon to be organized will consist of one representative of each of Florida's 15 congressional districts; three appointees of the Florida Medical Association; one appointee of the Florida Medical Political Action Committee, and four officers.

Appealing to FMA members to become FPA members by paying the \$15 annual dues, Dr. Cook reasoned that Florida physicians can look to FPA for assistance should the practice of medicine ever come under government control. As long as FMA leaders with Jim Cook's "no strike" philosophy keep control there should be no limit to applications.

Robert E. Windom, M.D., Chairman of the Council on Voluntary Health Agencies, reported on FMA's program of recognizing voluntary health agencies, and appealed for physicians to become active in them at the local level.

Pinch hitting as a speaker "to be announced," W. Harold Parham, FMA Executive Vice President, gave a detailed account of the "FMA Professional Liability Insurance Program." He traced the history of FMA-sponsored PLI programs from its beginning to the present program now being underwritten by Argonaut Insurance Company.

To date more than 4,300 physicians have applied for coverage under the new program which looks as if it were everything for which we could ask. It's obvious, however, that the program's success or failure will depend on how carefully each county society surveys its own members who apply for coverage.

Michael J. Pickering, M.D., Chairman of the Committee on Continuing Medical Education, reported on the committee's plans for implementing a mandatory program for FMA members. He expressed the hope that county medical societies will find it possible to keep records of continuing education credit on their own members.

Concluding the day's program was an illustrated report on emergency medical services by Roy M. Baker, M.D., Chairman of the Committee on Emergency Medical Service. His enthusiasm displayed his pride in Jacksonville's model emergency rescue service.

Highlight of Sunday's Seminar on Medical Legislation was a panel discussion of "State and National Issues and the Individual Physician in the Political Process." Participants included Sanford A. Mullen, M.D., Chairman of the Council on Legislation and Public Agencies, moderator; newly-installed Democrat Congressman Bill Gunter of Florida's Fifth District; State Senate Minority Leader, David C. Lane, M.D., of Fort Lauderdale, and Rep. T. Terrell Sessums, Speaker of the Florida House of Representatives.

Sunday, at the seminar on medical education, Congressman Bill Gunter from Florida's 5th congressional district received a standing ovation after his lucid and inspiring discourse from a conservative viewpoint on how the private sector of medicine must be included in planning any change in delivering health care. He remarked that polit-

ical action groups like FLAMPAC are of great help to those candidates they support but he called for personal involvement of physicians and their families as well in campaigns. Commenting on health issues, he said, "I am convinced the medical profession wants the very best for those ailing in mind or body." Observing that the public sector now picks up 40 per cent of the nation's health care tab, the freshman congressman doubted that "massive doses of federal money" would solve all problems in the health delivery system. He said he would oppose any national health legislation that does not use the private delivery sector and that does not assume freedom of choice of physician.

Rep. Sessums said that despite liberalization of the Medical Practice Act over the past four years, Florida still does not have enough doctors, but the problem of maldistribution of physicians may be partially solved by the Community Hospital Education Act of 1971. He suggested that the University of Florida might reduce its medical curriculum to three years; that double sessions be considered, or that a third state-operated medical school might be established in conjunction with existing institutions in Miami, Boca Raton, Orlando, Jacksonville or Pensacola. Turning to his second subject, the Speaker remarked that workmen's compensation is one of the few programs in which a patient cannot select his own physician, resulting frequently in a hostile attitude between patient and physician. He proposed amending the Workmen's Compensation Act to provide for free choice of physician.

Concluding the program, Senator Lane explained why he entered politics: "When the government started getting interested in my business, I started getting interested in government."

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AMA's BOARD OF TRUSTEES has approved a report by the Advisory Committee on Professional Standards Review Organizations calling on individual organizations represented on the committee to voluntarily create a moratorium on the establishment of PSROs until more information about the law and regulations becomes known. The advisory committee agreed that the AMA should assist in the establishment of PSRO areas; be instrumental in the development of rules and regulations; develop prototype PSROs; develop guidelines and norms for evaluating quality care; initiate mechanisms in cooperation with other organizations to assist in the formation of PSROs, train personnel, assess legal requirements and identify data accumulation needs.



# Report of the Ad Hoc Committee on Medicaid to the FMA Board of Governors January 13, 1973

ALLYN B. GIFFIN, M.D., *Chairman*

It is the opinion of this committee that the United States Congress in passing the Medicaid (Title XIX) Law was attempting to eliminate the welfare approach to medical care for the categorically indigent and even the medically indigent. It is further the opinion of this committee that the Legislature of the State of Florida, failed both in its philosophy and appropriations to carry out the dictates of the Congress.

If the State of Florida is to adequately care for the medical needs of the indigent and medically indigent, basic changes in the present Medicaid program must be made. As the representative of the physicians of the State of Florida, the FMA must steadfastly maintain three basic tenets in helping the state government develop a health care plan for the indigent.

1. Quality of care for the patient must be the number one priority. This should be at the most reasonable cost possible for the services rendered.
2. Freedom of choice for the patient must be maintained.
3. The independence of the provider must be respected and adequate compensation must be provided to motivate the provider to participate in the Medicaid program if the patient is to receive quality care.

The reason this committee has asked me to report to the Board of Governors of the FMA at this early date is because we have arrived at two proposals to correct the deficiencies of the Medicaid program, based on these basic tenets. The first proposal is as follows:

- A. Every effort should be made to get every person covered by the Medicaid program under the care of a physician. What every person needs is a doctor! He does not need

a bureau, a clinic, an agency. If the patient has a personal physician (who may be in solo, group, clinic or H.M.O. practice) he is in the mainstream of medical care.

1. In order to make this possible the number of physicians who will accept Medicaid patients, and the number of patients they will accept must be increased. This will only be possible by adequate payment for services rendered. At this writing the FMA will not accept a fee schedule, and the Department of H.R.S. and the legislature will not accept usual, customary and reasonable fees as a basis of funding; therefore, this committee recommends that the Florida Relative Value Study with an adequate conversion factor be used, as now being done by the Division of Vocational Rehabilitation, to determine the payment under Medicaid.
2. Secondly, the system itself must be changed so the patient may be able to receive care with less administrative problems.
  - a) Pre-authorization for an illness should be eliminated. Rather the patient should be authorized for care for a certain period of time, 1-3-6 months.
  - b) The time limit for billing should be eliminated or extended. If the service is rendered, the provider should be paid at whatever time the care is completed and billing submitted.
3. To assure quality of care at reasonable cost, Utilization and Quality review by the peer review mechanism should be instituted. This should not wait, but the necessary data should now be accumulated, so that an adequate peer review system for Medicaid can be established in the immediate future. The department of H.R.S. should enter into a contract with the Flor-

---

Dr. Giffin is chairman, Ad Hoc Committee on Medicaid.

ida Medical Foundation to carry out the review program.

B. Every effort should be made to get the patient under the care of a physician. (as increasing physician participation becomes a reality).

1. The social services of the Division of H.R.S. should make a concerted effort to match patient and physician, and to insure that the patient actually enters into a relationship with a physician; always retaining the freedom of choice for the patient.

2. The entire direction of Division of Health should be to use the present screening program as a method to get patients (children) under the care of a physician for the screening exam and follow-up care for medical problems detected by this program. To tolerate the gymnasium type of physical exam, or public health nurse examinations, and call this quality care is unthinkable in this age of medical sophistication. We realize that this could not all be done at once, but with the increasing number of physicians in Florida, and with the cooperation of the Florida

Pediatric Society, the Florida Association of Family Practice and local medical societies, a good start could be made.

C. It is the further recommendation of this committee that the present coverage for Medicaid recipients should be expanded to include preventative care. It is unreasonable to establish a medical care system, and then prevent preventative care. The following should be included immediately.

1. Neonatal care
2. Well baby care—5 visits first year, two the second year—one thereafter.
3. Routine physical evaluation 1-3 yrs.
4. Eye examinations
5. Obstetrical care—adequate payment.

D. It is further the recommendation of this committee, that the legislation be changed so that assignment is not mandatory under Medicaid, so that the physician would be allowed to determine whether he wants to be paid directly by the government or by the patient. In the long run it is our belief that the welfare of the patient could best be served by making him responsible for the payment for services rendered, and he could be paid by the government.

## Auxiliary Recipe Book

The Woman's Auxiliary to the Florida Medical Association is compiling a cookbook to be called "What's Cooking Doc?" Proceeds will be channeled to the History of Medicine Museum in St. Augustine and to funds for student loans, medical research, health education and other projects of the Florida Medical Foundation.

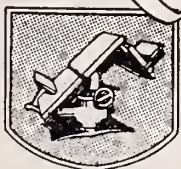
The Auxiliary invites FMA members and their wives to submit their favorite recipes for publication in the cookbook. Contributors are asked to doublecheck for accuracy the ingredient proportions, mixing instructions, cooking time, etc.

Recipes should be sent to Mrs. Eugene G. Peek Jr., Co-chairman, Woman's Auxiliary Florida Medical Foundation Committee, 303 S.E. 15th Avenue, Ocala, Florida 32670.

J. Jerry Slade  
E. Stewart Irwin  
G. Robert Garrett  
Philip D. Diuguid  
Clyde C. Young

Fifty-Six Years in Florida

Beatty Williams, Jr.  
William H. Norman  
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Kenneth I. Scarbara



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# The Committee of Seventeen

Brief Summary of Actions of the Committee on December 2, 1972, as well as a list of issues discussed.

The Committee of Seventeen expresses its profound sympathy to the family of Dr. Alfred L. Lewis Jr. at his tragic and sudden premature demise. Doctor Lewis was a good and faithful member of the Florida Medical Association Committee of Seventeen. His presence among us, his quiet friendly manner, and his wise counsel will be missed by all.

The Committee continued its investigation into the issue of notifying physicians of time and amount of payment to patients on unassigned Medicare B claims. Florida physicians want an automatic notification at the time the claim is paid. Medicare regulations will allow Blue Shield to notify the physician only if they receive an authorization signed by the patient, after the claim has been paid.

The November, 1972 issue of Medicare Newsnotes from Blue Shield informed all Florida physicians that Medicare regulations have been changed, and a physician or his employee can now witness the mark of an illiterate or mentally or physically handicapped patient.

The Committee gave the local medical societies insurance review committees a vote of confidence by recommending to the Florida Medical Association Board of Governors that the State Health Insurance Committee notify local insurance review committees whenever the state committee does not

endorse the decision of the local, before any final disposition is made on any claim.

By government decree, a less than 1% sampling of all Medicare B claims must be verified. This verification is presently being done by telephone. The Committee suggested that Blue Shield publicize this program to all physicians in their Medicare Newsnotes.

The Committee recommended that the Blue Shield Board should consider reimbursing all physicians who give their own anesthesia as outlined in the surgery section of the 1971 F.M.A. Relative Value Study, using only the base value but no time component.

The Committee called to Blue Shield's attention, some of their older contracts which are inadequate for today's health care needs. The Committee was informed that Blue Shield is attempting to phase those out.

When faced with a request from an ophthalmologist to ask Blue Shield to make surgical assistant allowances in cataract surgery, the Committee referred the issue to the Florida Society of Ophthalmologists for an opinion.

Other issues discussed by the Committee were:

- H.R. 1 (Medicare changes)
- Blue Shield Usual, Customary and Reasonable Contracts
- Child Psychiatry Utilization
- Physicians Assistants
- National Health Service Corps Physicians
- New Blue Cross-Blue Shield Group for State Employees.

Any questions regarding this summary can be directed to members of the Committee or the Committee staff.

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The Committee of Seventeen is FMA Advisory Committee to Blue Shield and Fiscal Intermediaries.

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## It's The Law . . .

"A physician may terminate the pregnancy of an unmarried female who is eighteen (18) years old or older upon her written request alone, and the failure to obtain the written permission of such person's parent or guardian is not a violation of Chapter 72-196, Laws of Florida, 1972."

Robert L. Shevin  
Attorney General  
State of Florida

1973

FLORIDA MEDICAL ASSOCIATION  
99th Annual Meeting  
Americana Hotel, Bal Harbour, Florida  
May 9-13, 1973

	May 9 Wednesday	May 10 Thursday	May 11 Friday	May 12 Saturday	May 13 Sunday
A. M.	Set Up EXHIBITS  10:00 General and Delegates Registration	8:00 Blue Shield Annual Mtg.  10:00 Ref. Comm. Nos. V & I 10:30 Ref. Comm. Nos. IV & II 11:00 Ref. Comm. No. III  VISIT EXHIBITS 8:30-4:30	9:00 Scientific to Sections & 10:45 Specialty Groups  VISIT EXHIBITS 8:30-4:30 11:00 General Session (Baldwin Lecture)	9:00 Specialty Groups and Scientific Sessions  VISIT EXHIBITS 8:30-3:00	8:00 Prayer Brkfst.  9:00 Third House of Delegates
P. M.	4:00 First to 5:30 House of Delegates	2:00 Scientific Sections 5:00  (Reference Com- mittees, if necessary)	12:15 Auxiliary & to 2:00 Flampac Luncheon  2:30 Scientific to 5:00 Sections & Specialty Groups	1:00 Specialty to 2:45 Groups  3:00 Second House of Delegates	Post- Convention Board of Governors
E V E N I N G			6:30 President's Reception  7:30 Alumni & Fraternity Socials	Dismantle Exhibits  Specialty Group Socials	

There will be some 35 scientific sections covering a wide range of topics held on Thursday, Friday and Saturday during the FMA annual meeting this year. In addition, approximately 28 recognized specialty groups will hold individual scientific and business meetings in conjunction with the meeting.

There will be 65 exhibits composed of scientific and technical exhibits open for viewing on Thursday, Friday and Saturday.

The speaker for the annual WA/FLAMPAC luncheon will be announced in the April issue of the Journal along with the president's guest speaker who will present the Baldwin Lecture.

Fishing, Golf and Tennis Tournaments will be held again this year. Complete information on these tournaments will appear in the April issue of the Journal.



## Health Programs and Problems

*Editor's Note: The following is excerpted from an address by Dr. William J. Dean, FMA president, before the Health Care Committee of the Florida Council of 100 on November 1, 1972.*

FMA is currently made up of some nine Councils and seventy Committees. As an example, we have committees and subcommittees working in the field of quackery, venomous snake bites, child health, migrant workers, maternal health, emergency medical care, medical students, college health, Workmen's Compensation, Indian Health Affairs, medical education, and drug abuse.

In reply to the frequently heard comments that in our country today there is a health crisis in existence, the newspapers and other media have sold the American public on the notion that there is a crisis today, but I actually believe this is not true. More people in our country are receiving better medical care than ever before in the past, and the medical care in our country is the best offered in any country in the world. We don't pretend that our system is perfect and we strongly advocate any change that will improve our current system. Our first objective is quality medical care. Many of our politicians in both political parties are advocating better care, more sophisticated equipment, and more availability of care for all peoples in our country. These are obviously fine goals, and we are all working towards this but we do strongly feel that many of these objectives would definitely increase the cost of medical care. This cost of medical care is undoubtedly one of our greatest problems today. In 1971, the cost of medical care for each person in our country was \$358. This is a price tag of \$1,432 for each family of four. One dollar out of every \$14 of our gross national product, which is over a trillion dollars a year, is spent on health care. This amount of money, of course, is big business and actually commands the attention of our leaders in Washington, as well as elsewhere. Out of this staggering figure, the government is providing about 40 cents of every dollar, and private health insurance about 24 cents of every dollar.

With the tremendous expenditure, it is not surprising that National Health legislation pro-

posals are coming from all sides. Senator Kennedy's plan of everything for everybody is at one end of the scale, and Mr. Nixon's plan for encouraging HMOs seems to fall somewhere near the middle of the scale.

In regards the opinion of organized medicine as relates to the Health Maintenance Organization concept seem to be in order; the AMA and the FMA do not oppose the HMO concept, but feel that it must be tried and proven before accepted for the masses of our people. Currently, in Florida, we have under our Florida Medical Foundation a study going to survey the State and determine the practicability of HMO's serving our people. There have been over a hundred federal grants already issued to organizations to form or start HMOs, and we agree strongly with Congressman Paul Rogers in his idea of reviewing these plans over the next three years, and determining the feasibility of this type of pre-payment medical care. One of the great ideas for saving of money under the HMO system is in the field of preventive medicine. Although we must continue to strive to improve our health care through preventive medicine, we, in organized medicine, feel that this has probably been over-stressed and that a truly preventive medicine program on a larger scale may actually prove to be more costly rather than saving money in the long run.

Another problem that we have in Florida, as well as the rest of the country, is distribution of medical care. Medical schools throughout the country are producing more physicians each year, and there have been four new medical schools opened in our country in the year 1971. In 1971, there were approximately 1,700 more physicians graduated from medical schools than were graduated in 1963. In our growing State of Florida, there has been a dramatic increase in the number of physicians licensed by our State Board of Medical Examiners since removal of the Basic Science examination several years ago, and the

institution of reciprocity with other states, passed by our legislature last year. In the past, the State Board had been licensing some 400 to 500 doctors a year, while last year the State Board licensed 2,000 new doctors in Florida, and up to July 1 of this year, some 1,500 new doctors have been licensed. There are approximately 9,000 doctors currently licensed and practicing in the State, and there is another 9,000 who hold Florida licenses but are not currently practicing in the State. We wonder that when these 9,000 nonresidents decide to come to Florida, if there will be an actual surplus of physicians in our State.

The Medicaid program in the State of Florida for the so-called medically indigent resident has not proven to be a good program, in our opinion. The appropriation of matching funds by our State legislature has been most unsatisfactory, and we are currently working diligently in Tallahassee to have this program updated. Our physicians have been discriminated against in that they are receiving sixty per cent of their usual and customary fees for patient care, whereas medical services other than physician fees have been receiving one hundred per cent of their charges. This is a situation that stands to receive real indepth study by our politicians, and we in organized medicine are hoping to reach some type of satisfactory agreement with them.

Comprehensive Health Planning in Florida is just getting underway and your own Mr. Robert Sheen is a new member of this State committee. We are hoping that the medical input to this com-

mittee will be of sufficient standing to insure better medical care for all of our citizens. A lot of work and study will necessarily need to go into this program.

The Florida Medical Association is backing the federal government's recently inaugurated program called the National Health Service Corps. This is a program by which young men completing their medical training are sent into communities or areas of poverty where there is a true lack of medical care. These men serve a two year period, which frees them of their obligation to the government, and the program is made, we hope, attractive so that some of these men will remain in these communities after their obligatory period of service is completed.

These are simply a few of the programs and problems that we in the Florida Medical Association see for our State. We are hoping to continue to build and improve on our present program which has been in effect in our country for some two hundred years. We feel that improvement upon these tried and proven methods of delivering medical care will be the answer rather than a revolutionary shakeup, and adoption of some massive new program that has not had the test of time. We do hope that your organization through education and study of health problems can help us in securing better care for all of our people.

► Dr. Dean, 1515-4th Street, N., St Petersburg 33704.

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How much easier it is to write a ton of books on pedagogy than to produce one teacher of sensitive structure, noble manner, and fine taste, whose essential presence and inward habit are a constant dissuasive to vulgarity and a living recommendation of the beauty of learning and the dignity of wisdom!

*William L. Sullivan*  
*Epigrams and Criticisms in Miniature*



## Medical News

### Topics in Internal Medicine

The "Fourth Annual Topics in Internal Medicine" course will be conducted May 28-30, 1973, at the University of Florida in Gainesville. (Dates changed from May 9-11).

A registration fee of \$100 will be charged. Information may be obtained from Mrs. Charlene H. Taft, Program Coordinator, Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville, Fla. 32601.

### Epilepsy Clinic at Miami University

The University of Miami School of Medicine has established an epilepsy clinic within its Department of Neurology.

The clinic will be conducted on Thursday mornings under the direction of Todd Troost, M.D., of the Department of Neurology.

### Dr. Prystowsky Gets Penn Post

Harry Prystowsky, M.D., Chairman of Obstetrics and Gynecology at the University of Florida Health Center in Gainesville, has been named Provost of the Hershey Medical Center and Dean of the Pennsylvania State University's College of Medicine.

The 47-year-old physician, who has been a member of the faculty of the J. Hillis Miller Health Center since 1959, will assume his new post this summer. He is a member of the Alachua County Medical Society and the Florida Medical Association. He is a former president of the Association of Professors of Gynecology and Obstetrics, and in 1959, the National Jaycees named him one of the ten outstanding young men in the nation.

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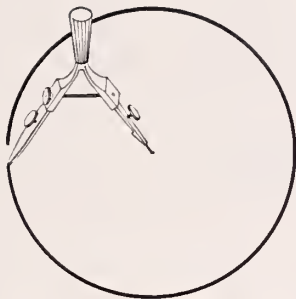
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## Letters

Dear Editor:

You will recall that the Food and Drug Administration's Bureau of Radiological Health has responsibility for developing and administering a radiation control for health and safety program as authorized by Public Law 90-602. Under that program, a radiation safety performance standard for diagnostic x-ray equipment was published on August 15, 1972, to become effective one year later.

The Bureau recently learned that some dealers have been advising physicians and other users that all existing x-ray equipment will have to be upgraded to meet requirements of the standard by the effective date of August 15, 1973. You may be able to perform a service for your readers by informing them that such advice is contrary to fact.

Upgrading of x-ray equipment now being used is not now required by the standard. State and territorial radiation control authorities have been asked by the Bureau to so inform equipment users and dealers.

Our communication to the States and territories made one other point. This was that, although equipment now in use will not have to be modified before the standard becomes effective, owners installing manufacturer-certified components in such x-ray systems after next August 15 must install components of the type called for by the Federal standard.

Additional information about the standard may be obtained from the Division of Electronic Products, Bureau of Radiological Health, Food and Drug Administration, 12720 Twinbrook Parkway, Rockville, Maryland 20852.

JOHN C. VILLFORTH, DIRECTOR  
BUREAU OF RADIOLOGICAL HEALTH

Dear Editor:

Dr. Philip B. Phillips article "What Is Your Community's M.S.S.Q.?" in the January Journal of the Florida Medical Association was most interesting.

Perhaps a similar study could be done by every county medical society in the State of Florida.

Also, the article in the same issue re "The British National Health Scheme," by Dr. Everett Shocket was very interesting.

My wife and I spent a month in London in 1972 and came away with very much the same feelings that he expressed. I'm inclined to feel that we need some system in the United States that works as well as the British system works for England.

T. NORLEY, M.D.  
WEST PALM BEACH

To the Editor:

I certainly enjoyed Dr. Everett Shocket's article in the Journal of the Florida Medical Association of January 1973 regaling his experience with the British National Health scheme. I have just returned from London, meeting people there, I believe he has given a very good report of the British Health System, though I think his summary is a sort of tongue-in-cheek one to keep from offending the powers that be in American medicine.

I, too, don't think that the British Health System can be transplanted to the United States, as I don't believe one can transplant British television programs, their cinemas, or their journalistic attainments as you might have noted how they report the war in Vietnam compared to our American newspapers.

I think the conclusion is not whether the British National Health System should be duplicated in our country, but that whether our country needs a national health system, understanding the cultural, economic, and social differences between the two countries. This is a point which I believe he has willingly shunted or disregarded.

Still, with my best and hopefulness that we do have some forward looking physicians in the profession, I remain

HARRY E. BELLER, M.D.  
MIAMI

To the Editor:

The Florida Special Olympics is again turning to the Florida Medical Association for support

and cooperation, as last year, in providing medical advice, guidance and expertise for the retarded.

Last year, some 3,000 volunteers participated in making the Olympics a success along with some 6,000 retarded who participated on the local, regional, state and national levels.

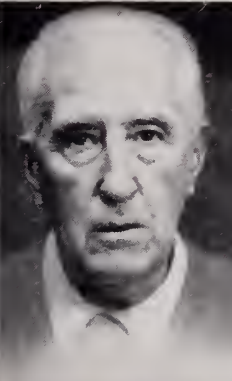
This year there will be no national meeting. The local meets will be held before March 31; the regional meets before May 5, and the state meet is scheduled for June 15-16 at the University of Florida in Gainesville.

By copy of this letter to each Area Coordinator and the physicians who participated last year, I am asking those physicians if they will again serve this year. The Area Coordinators should feel free to add any other names of physicians who are interested in helping, advising me of the names added.

Thank you very much.

T. NORLEY, M.D., *Chairman*  
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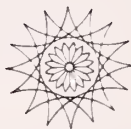
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By

Timothy A. Lamphier, M.D., F.A.C.S., et. al.

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Preface by

Herbert D. Adams, M.D.

Former President—

Lahey Clinic Foundation

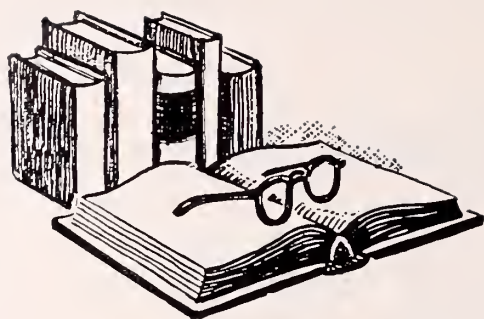
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## Book Reviews

**William Carlos Williams, *The American Background*** by Mike Weaver, 228 Pp., Price \$9.50. New York, Cambridge University Press, 1971.

This scholarly book by Mike Weaver attempts to interpret the work of and the influences on America's most famous contemporary physician writer-poet. It presupposes familiarity with Dr. Williams' writings. I was not, but the book sent me scurrying to become so.

William Carlos Williams graduated from high school in Rutherford, New Jersey, attended the University of Pennsylvania School of Medicine directly from high school, and after internship in New York City received graduate training in pediatrics in Leipzig. He then returned to Rutherford to practice medicine and write. He died in 1963 at age 80.

Perhaps his single, best-known literary work is a long epic poem, *Paterson*. This is divided into five sections or books. Williams intended *Paterson* to represent both a man and a city.

Although Dr. Williams was a prolific writer of poems, novels and short stories, Weaver quotes him as saying he never made more than \$200 in any year on his writings.

At one point in his life, Dr. Williams was caught in a double-bind. "He was investigated by the FBI as a fascist friend of [Ezra] Pound, and indexed by the House Committee on Un-American Activities as a communist."

This reviewer suggests that, if interested, you read *Kora in Hell*, *Paterson*, and Williams' autobiography; then read Weaver's book. This book is a valuable, well-researched contribution to our understanding of the person and the writings of this physician writer-poet.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Radiation Protection Standards** by Dr. Lauriston S. Taylor. Price \$11.50. Cleveland, Ohio, CRC Press, 1971.

With all the public concern about radiation exposure over the last 20 years there have been numerous newspaper headlines describing the lack of interest by governmental and other agencies in protecting the public from this hazard. As a matter of fact, scientific awareness of the problem goes back to before 1928 when an "International Advisory Committee on X-ray and Radium Protection" (ICRP) was established under the auspices of the Second International Congress of Radiology meeting in Stockholm. Dr. Lauriston S. Taylor, the author of this book was a member of the original committee. He traces the history of effort to regulate radiation exposure over the years with the activity of the ICRP, the formation of the National Council on Radiation Protection (NCRP) and the various other public and private organizations that have been active in the radiation protection field. It is interesting to know how conservative most of the original recommendations for radiation exposure were 30 to 40 years ago. There has been relatively little change in recommended radiation exposure even as more firm scientific data on radiation effect have been accumulated. The book lists the various reports and recommendations of radiation protection agencies quoting many of them in detail. For this reason it makes for rather dry reading for the average medical practitioner but it certainly does provide solid reasonable answers to many of the hysterical questions being asked about radiation exposure and protection of the public today. It should find a useful place in a society speaker's bureau reference file.

LAWRENCE H. JACOBSON, M.D.  
MIAMI

**Review of Medical Microbiology**, 10th ed., by Ernest Jawetz, M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 518 pages. Price \$8.00. Los Altos, Calif., Lange Medical Publications, 1972.

This is the tenth edition of what is possibly one of the best text books available on Medical Microbiology.

The first 160 pages of the book are concerned with such basic fundamentals as Bacterial Classifications and Genetics, Microbial Metabolism and Growth Requirements, Bacteriophage, Microbial Therapy, Host-Parasite Relationships and Immunologic Phenomena, and are very adequately covered. Then follows a well-written 100 page systematic review of medical bacteriology, then a brief expose of medical mycology containing only two pages devoted to the superficial mycoses. Considering the high incidence of these infections, this is surely an oversight on the part of the authors.

Some 200 pages are devoted to virology. Chapter 28 on virus isolation is particularly lucid although the section on tissue culture techniques could well be expanded. These techniques are, after all, the greater part of virus isolation.

The section on the Arboviruses lacks clarity, but this failing is not unique to this book. The fact is that the Arboviruses form an extremely large, diverse, poorly understood group of viruses and as such they are difficult to classify and discuss. The authors have done little to help matters. When revising for an examination, the medical students to whom the book is directed, would appreciate greater clarity. To some extent this could be achieved by doing away with the wretched horizontal tabulations and by replacing them with the familiar lists so beloved of medical students. Clarity of presentation would seem a worthwhile objective even at the expense of a few extra pages.

The remaining chapters complete what is otherwise an excellent section on virology, containing much new information and a few new words (e.g., diplomavirus, coronavirus). The book ends, as in previous editions, with a relatively brief index on parasitology. It is an excellent book at any price and at \$8.00 it has to be a bargain.

MALCOLM C. FREEMAN, M.D.  
ELMHURST, ILLINOIS

## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Current Pediatric Diagnosis Treatment**, 2nd Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. Pp. 1008. Illustrated. Price \$12.00. Los Altos, California, Lange Medical Publications, 1972.

**A Laboratory Manual for Exercise Physiology** by Donald J. Byrd, Ph.D. and Freddie M. Browning, Ph.D. Pp. 158. Springfield, Illinois, Charles C. Thomas Publisher, 1972.

**Developments in Horney Psychoanalysis** edited by Jack L. Rubins, M.D. Pp. 335. Price \$12.50. Huntington, New York, Robert E. Krieger Company, 1972.

**The Structure and Biological Functions of Histones** by Lobomir S. Hnilica, Ph.D. Pp. 213. Illustrated. Price \$25.00. Cleveland, Ohio, CRC Press, 1972.

**Current Concepts in Radiology** edited by E. James Potchen, M.D. Pp. 346. 502 Illustrations. Price \$24.75. St. Louis, The C. V. Mosby Company, 1972.

**Is My Baby All Right?** by Virginia Apgar, M.D. and Joan Beck. Pp. 492. Illustrated. Price \$9.95. New York, Trident Press, 1973.

**Renal Disease in Childhood** by John A. James, M.B. Pp. 377. 116 Illustrations. Price \$23.50. St. Louis, The C. V. Mosby Company, 1972.

**Risks in the Practice of Modern Obstetrics** edited by Silvio Aladjem, M.D. Pp. 304. 74 Illustrations. Price \$29.50. St. Louis, The C. V. Mosby Company, 1972.

**Family Planning Education, Parenthood and Social Disease Control** by Charles William Hubbard, B.S., M.P.H. Pp. 173. 48 Illustrations. Price \$3.95. St. Louis, The C. V. Mosby Company, 1973.

**Heritable Disorders of Connective Tissue**, 4th Ed. by Victor A. McKusick, M.D. Pp. 878. 1099 Illustrations. Price \$32.50. St. Louis, The C. V. Mosby Company, 1972.

**Current Diagnosis Treatment** by Marcus A. Krupp, M.D. and Milton J. Chatton. Pp. 996. Price \$12.00. Los Altos, Calif., Lange Medical Publications, 1973.



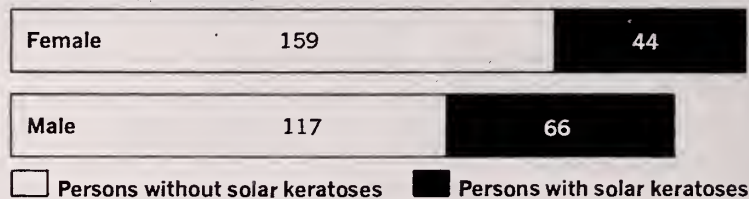
# What it means to live and work in Tipton County, Tennessee

**Persons who are white and  
over 40 have one chance in four  
of having solar keratoses...  
which may be premalignant**

An epidemiologic study\* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons  
over 40 in Tipton County, Tennessee**



\*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



## Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

## Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)\* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

## Cosmetic results

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

## 5% cream—a Roche exclusive

Only Roche formulates the 5% cream... high in patient acceptability... high in clinical efficacy, especially for lesions of hands and forearms... economical.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

## an alternative to conventional therapy **Efudex<sup>®</sup>** (fluorouracil) cream/solution



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## Woman's Auxiliary

### "With the Help of My Friends"

Dear Doctor:

The words of that song could be amended to "with a lot of help from our friends," because that's truly the case with our upcoming Statewide Health Education Conference. From the first planning session in Tampa in late November, when state leaders in health and education professions conferred and jointly agreed upon our conference format, support and enthusiasm have grown and your auxiliary president has found many new friends. The plans are complete and you are invited, although an invitation is not in order, since you, as a member of FMA, are assisting the auxiliary in sponsoring the meeting. I most gratefully acknowledge the added assistance of our co-sponsors, the Division of Health, FRMP and Department of Education, as "a lot of help from our friends."

The two day conference will convene at 10 a.m. on March 15th at the Hilton Inn, St. Petersburg, with greetings from FMA President William Dean. The program will focus on "Finding Solutions for the Complex Health Problems of our Youth." Authoritative speakers, outlining these problems, will include Dr. Wallace Ann Wesley, Director, Health Education Division, AMA; Robert D. Russell, Ed.D., Associate Professor of Health Education, Southern Illinois University; Ronald Deutsch, author and nutrition lecturer, and Mr. Emmett Roberts, Secretary, Department of HRS.

The following day, March 16, FMA Legislative Committee Chairman, Sanford A. Mullen, M.D. will discuss "Health Education Legislation in Florida," with distinguished panel members from both the Senate and House committees on health and education.

Workshop sessions on both days will include leaders and medical, dental, education and auxiliary consultants and designated representatives from organizations with health related committees . . . and most important, representatives from each county auxiliary. This is where "the action" is . . . this sharing of ideas, information and re-

sources invariably lead to better understanding and eventual solutions.

Programs to promote better health are certainly new to county auxiliaries, in fact, that's what we do best! In recent months, the Sarasota and Manatee County girls, (following Pinellas County's example) presented "The Woman's Worry Clinic," offering professional advice to women of all ages. In Orange County, members planned a seminar for physical education instructors and coaches, "The Prevention and Treatment of Athletic Injuries," enlisting local physicians to panel this vital program. Countless programs on drugs, VD and other current health problems are conducted. In Charlotte County, observing January as National Blood Donor Month, this small but mighty group of M.D. wives sounded a telephone alert for donors. The individual contributions sometimes go unheralded, as in the case of a Duval County member who writes a regular column in "The Heart Beat," a publication of N.E. Florida Heart Association, sharing her favorite low-cholesterol recipes with readers BUT WITH ALL THIS WOMAN-POWER, WE CAN STILL DO MORE!

Your state auxiliary views this conference as our opportunity to express your long held conviction that preventive medicine, through education, provides the solution for many health problems. It is in this area we can best help you, but *we* must first be well informed and aware of the problems, and this statewide conference can serve as our guideline. Your wife and I can return to our communities and share what we've learned, creating better understanding among our neighbors, and perhaps instituting similar round table conferences if necessary. Proportionately, there aren't too many of us, . . . but, "with a lot of help from our friends. . . ."

DR. JIM'S WIFE

MRS. JAMES J. (CATHERINE) DeVITO  
PRESIDENT, WA/FMA

# Seventh Annual Benefit Art Show

## Exhibit Rules and Regulations

### Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.).
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of \$10.00 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than May 1, 1973.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Americana Hotel no later than 4:00 P.M. Wednesday, May 9. Shipped entries will be refused.
8. All entries must remain on exhibition until 12:00 P.M. on Saturday, May 12.
9. We will not be held responsible for entries not picked up before 1:00 P.M. Saturday, May 12.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to the St. Augustine Medical Museum.

Kindly enter my registration to show in the Benefit Art Show.

Fee of \$\_\_\_\_\_ for \_\_\_\_\_ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A Painting. Include any media in color: acrylic, oil, casein, collage, water color, pastel, etc. Size: \_\_\_\_\_ x \_\_\_\_\_. To be hung on wall.

( ) B Graphics. Include pen and ink, charcoal, photography, etc. Size: \_\_\_\_\_ x \_\_\_\_\_. To be hung on wall.

( ) C Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

( ) I am the son/daughter of a Florida physician. Age \_\_\_\_\_

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award" will be given and the winning entry will be used on the cover of a future issue of the FMA Journal.

A registration fee of \$10.00 will be charged for each entry. Make checks payable to:

Mrs. Ronald J. Mann  
6701 S.W. 125th Terrace  
Miami, Florida 33156

NOTE — It is important to note sizes in above spaces.

REGISTRATION DEADLINE MAY 1, 1973





**"What are fears but voices airy?  
Whispering harm  
where harm is not."**

Wordsworth

In HUMAN RESOURCE INSTITUTE'S new plan for care of the emotionally ill, custodial hospitals, locked wards, punitive staffs, and authoritarian administrative policies have given way to open wards, intensive active treatment, and a more egalitarian hospital community. HRI'S newly constructed cheerful facilities share a basic orien-

tation, the "therapeutic community." The efficacy of group and individual psychotherapy, somatic therapies and behavior therapies is enhanced when utilized within a therapeutic milieu. Rather than being seen as a detour from his main stream of experience, the patient comes to view the hospital as an integral part of his life

experiences and one that helps him put together the dislocated and disorganized pieces of his past.

For further information contact. David Pinosky, M.D., Medical Director, Human Resource Institute of Miami, Inc., 1600 N.W. 7th Court, Miami, Florida 33136



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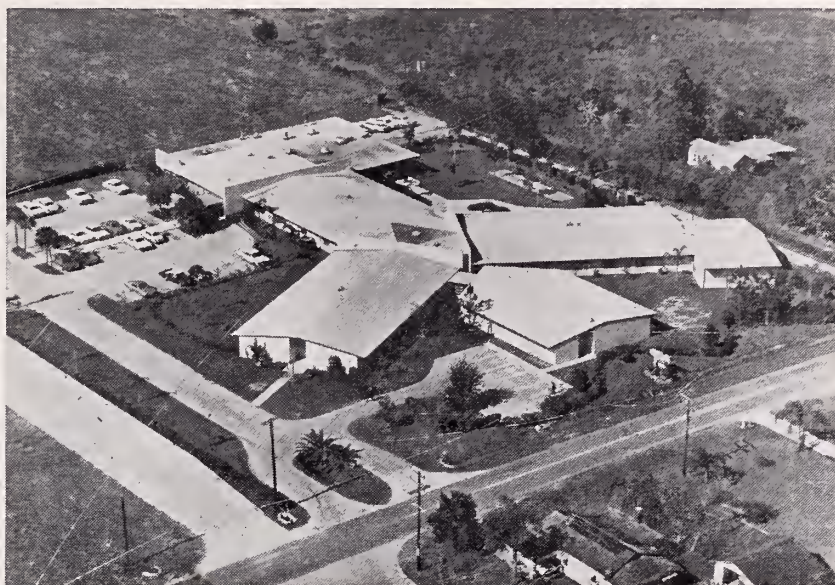
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# "Dedicated to the Understanding and Treatment of Emotional Illness"

LAKELAND  
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A  
*Modern Hospital  
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LAKELAND MANOR is a complete 66 bed private psychiatric hospital featuring the newest concepts of progressive patient care skillfully blended with PERSONALIZED ATTENTION, and offering on premise laboratory and radiologic facilities supported by medical and surgical facilities of the 550 bed Lakeland General Hospital.

58 private, semi-private and 4 bedrooms featuring the "open care" concept with patients supervised according to individual needs. PLUS a seclusion unit consisting of six single rooms and a double room, complemented by a spacious day area.

- \* Social Service Department
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Patients accepted age 13 through geriatric on voluntary or commitment basis. Most major health insurance plans acceptable.

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MEMBER: Florida Hospital Association; American Hospital Association; National Association of Private Psychiatric Hospitals; Provider of Medicare; Fully accredited by JCAH.



## Classified Ads

### physicians wanted

#### Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

WANTED GENERAL PRACTITIONER with possibility of future association in Miami. Please send curriculum vitae c/o the Journal of the Florida Medical Association, C-572, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PRACTITIONER to join 15 man multi-specialty group in Central Florida. Excellent fringe benefits together with pleasant working facilities in an area famous for excellent recreational opportunities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

FAMILY PRACTITIONER to join 4 man hospital based group in North-Central Florida. Pleasant working conditions and excellent salary. Contact Don F. Beazley, Administrator, Division Hospital, Box 587, Lake City, Florida 32055, phone (904) 752-2922.

#### Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST, board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Sub-specialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

INTERNIST-CARDIOLOGIST, Board certified or board eligible to work along with our present Internist-Cardiologist. Long established group in Hollywood, Florida. Must have Florida license and completed military obligation. Salary open. Write John F. Kerwick, Manager, P. O. Box 2308, Hollywood, Florida 33022.

TWO BOARD CERTIFIED INTERNISTS (55 & 35) seek young, board qualified, third internist. Good working conditions. Must have Florida license and no military obligation. Please send curriculum vitae with first letter. Contact Drs. Stone and Fineman, P. A., 1755 Adams Street, Hollywood, Florida 33020.

INTERNIST, Board certified or qualified to join two man internal medicine practice in North Palm Beach, Florida, with sub-specialty in cardiology preferred. Please send curriculum vitae to C-586, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN FOR ASSOCIATION: With pediatrician in busy central Florida area. Salary first year, percentage and partnership to follow. Florida license required. Write C-584, P.O. Box 2411, Jacksonville, Florida 32203.

#### Miscellaneous

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

**PHYSICIANS NEEDED:** Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners, Internists, and Allergist. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

**INTERNIST AND GENERAL PRACTITIONER** for association—Mid-East Coast Florida. \$24,000 guaranteed with excellent potential through participation in partnership. All expenses covered. Liberal benefits. P.O. Box 550, Cocoa, Florida 32922.

**DEVELOPING MULTISPECIALTY GROUP** oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Urologist, Internist, Cardiologist, Pediatrician, General Surgeon, Orthopaedist, and OB-GYN. Contact: H. D. Williams, M.D., President, Marlowe, Williams, Abbey & Sells, MDs, PA. Richey Medical Center, P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

**FLORIDA: E.R. PHYSICIANS.** Large coastal city. \$32,000 plus benefits for 42 hours first year. Florida license needed. Write P.O. Box 23723, Tampa, Florida 33622.

**CENTRAL FLORIDA AREA:** Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

**OPENINGS FOR FLORIDA LICENSED PHYSICIANS** in busy emergency room setting. Physician must have career commitment to trauma medicine. Excellent working conditions; generous remunerative arrangements. Send curriculum vitae to Mr. John M. Gardella, Assistant Administrator, Memorial Hospital, 3501 Johnson Street, Hollywood, Florida 33021.

**INTERNISTS, ORTHOPEDIC SURGEONS,** and other sub-specialties. Investigate Plant City, Florida to set up private practice. 129-bed hospital with nuclear medicine department. 58 additional beds available and equipped. Located between Lakeland and Tampa. Contact H. F. Holmes, Administrator, South Florida Baptist Hospital, Plant City, Florida 33566.

**EMERGENCY ROOM PHYSICIAN** — Opening available in mid-spring. Large modern medical center. Liberal benefits. For more details contact Jack Stephens, Broward General Medical Center, Fort Lauderdale, Florida 33316.

**PHYSICIANS WANTED:** St. Augustine (Flagler Hospital) desires the following Florida licensed physicians to meet the growing community needs: General Practitioners (2), E.R. Physicians, Internist, General Surgeon, Pediatrician, Otolaryngologist, Ophthalmologist. New professional building ready in July. Financial assistance available. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone (904) 829-5676.

**WANTED—MEDICAL TECHNOLOGIST** for 72 bed, general hospital. Salary range \$600-\$710, position now vacant. Apply by telephone or letter to T. S. Yeager, Administrator, Highlands General Hospital, 3600 S. Highlands Ave., Sebring, Florida 33870. (813) 385-6101.

## situations wanted

**INTERNIST, CARDIOLOGIST:** Board eligible, excellent credentials. Seeking position with a hospital or small group. Prefer cardiac catheterization facilities. Write C-585, P.O. Box 2411, Jacksonville, Florida 32203.

**OBSTETRICS-GYNECOLOGY and GENERAL SURGERY:** Board eligible, Florida licensed, general surgeon and obstetrician-gynecologist, seeking group association or partnership in central Florida (Lakeland-Orlando area). Available immediately. Write C-561, P.O. Box 2411, Jacksonville, Florida 32203.

**UROLOGIST:** Board certified, 36 years old, university trained, F.A.C.S.-F.I.C.S. Five years in private practice, desires to move to a warmer climate. Write C-588, P.O. Box 2411, Jacksonville, Florida 32203.



## practices available

**PEDIATRIC PRACTICE FOR SALE.** Well established 12 year old practice. Gross \$106,000. Southeast Florida coastal community. Not far from Miami. Excellent fishing and water sports; lovely weather. Modern, completely equipped condominium office. New hospital. Excellent terms, may purchase or lease complete package. Available July 1973. Write C-583, P.O. Box 2411, Jacksonville, Florida 32203.

**OUTSTANDING LOCATION FOR SPECIALIST:** St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

## real estate

**EXCELLENT OFFICE SPACE AVAILABLE:** 975 sq. ft. in the Five Points Medical Center, Oak and Lomax Sts., Jacksonville, Florida 32204. All utilities and services furnished. Will renovate to suit tenant. For information please call Dr. Max Mendelson at 355-5150.

**PRIVATE SUITES FOR IMMEDIATE OCCUPANCY:** New 18,000 sq. ft. building with excellent parking. South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

Classified advertising rates are \$5 for the first 25 words or less and 20 cents for each additional word. Deadline is first of month preceding month of publication.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P. O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

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Next Annual Meeting: May 9-13, 1973, Bal Harbour

# JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

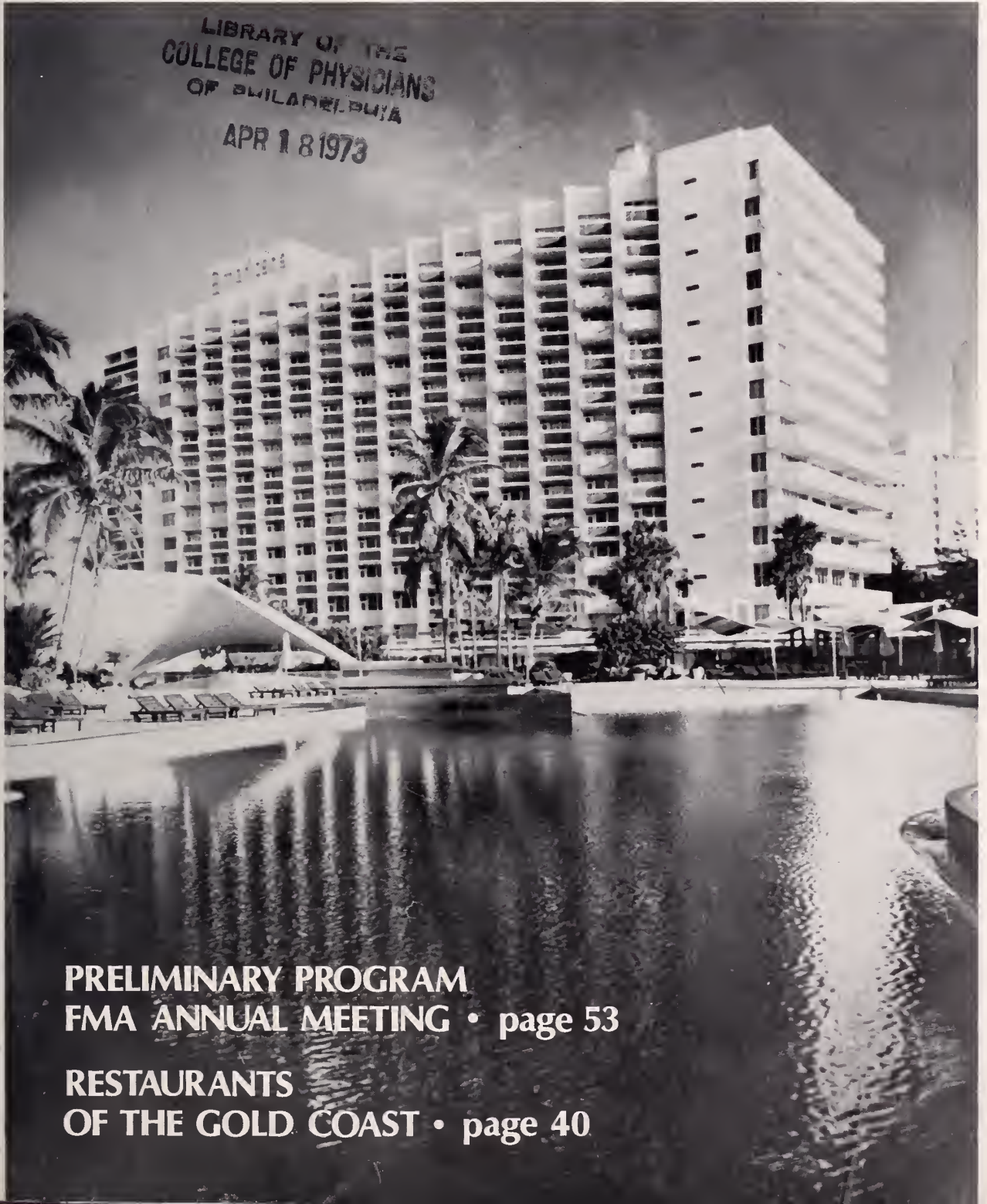


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**PRELIMINARY PROGRAM  
FMA ANNUAL MEETING • page 53**

**RESTAURANTS  
OF THE GOLD COAST • page 40**





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

APRIL, 1973 • VOLUME 60 • NUMBER 4



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APRIL COVER—Americana Hotel, Miami Beach—Site of Ninety-Ninth Annual Meeting of the Florida Medical Association, May 9-13, 1973.

## President's Page



### P.S.R.O.

These initials which stand for Professional Standards Review Organization may be somewhat foreign to many of us at this time but I am sure during the next 12 months we will all become more familiar with this phrase. The Bennett Amendment was passed into law as part of the mammoth H.R. 1 in October, 1972. Senator Bennett's amendment was modified in the House-Senate Conference Committee but does provide for review of patient care in hospitals under Medicare and Medicaid. The law states that the Secretary of HEW must designate areas in each state and that a Review Organization composed of M.D.s and osteopaths will review hospital care in its area. Senator Bennett and his group envision that each one of these organizations would sign a contract directly with the Secretary of HEW to carry out this review function. He proposed a state council composed of members recommended by the medical association, the Governor's office, the hospital association and consumers to oversee the individual P.S.R.O.s in the state.

The regulations which will spell out the operation of the program have not been formalized as yet but those of us who have studied the law fear that even though the individual P.S.R.O.s are made up of physicians, the state council, which would not be under control of organized medicine, might adversely affect the program for the patient and the doctor. Our FMA Board of Governors feels that a much better solution would be to have the State of Florida as a whole declared as one P.S.R.O. unit and then subcontract to individual regional groups for the actual review process. This method, in our opinion, would not fractionate the state and would cut down tremendously on the administration of the program. If we have, say, 10 P.S.R.O.s in the State of Florida that are reportable directly to the Secretary, this means that each organization would have to set up its own standards and norms plus contract for its own computer work and administration. If the state as a whole is one P.S.R.O. unit, one set of norms, one computer, and one administrative department could handle the entire problem. This seems to me to be the best approach and we hope that we can accomplish this goal.

I have heard some rumbling among our membership that we shouldn't cooperate with P.S.R.O. at all. This is a most impractical approach. Our AMA fought hard to prevent Senator Bennett's amendment from becoming law and we lost the fight. It is naive to believe now that we can get this law overturned, and I feel that the best we can do is to attempt to have the regulations and guidelines prepared in such a way that the patient and the physician will benefit. It seems logical to me that the government does have a right to see that the monies it is spending are spent in the best manner possible.

There is so much happening in and to our profession today that it becomes hard for those of us who are closely associated to keep up with all the facets. Time is at hand when all of us should devote more time and energy to understanding and knowing just what is going on. For this reason, I strongly urge all of you to plan now to attend our annual FMA meeting at the Americana Hotel in Bal Harbour in May. For those of you who usually don't attend and leave it up to your delegates, I hope that you will plan to go and see just what is going on. You might be surprised!

*William J. Dean, M.D.*



# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopeni malodor of the urine, crystalluria, hematuria; appearance of liv Ascaris in the mouth and nose. Hypersensitivity reactions

# A New Dosage Form:

**Chewable  
Tablets** 500 mg  
**Mintezol**<sup>®</sup>  
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so easy to take  
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side: fever, facial flush, chills, conjunctival injection,  
oedema, anaphylaxis, skin rashes, erythema multiforme  
(including Stevens-Johnson syndrome), and lymphadenopathy.  
indicated: Chewable tablets, containing 500 mg thiabendazole,  
boxes of 36, strip packaged, individually foil wrapped;  
suspension, containing 500 mg thiabendazole per 5 cc, in  
bottles of 120 cc.

For more detailed information, consult your MSD representa-  
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## INDICATION | DOSAGE SCHEDULE

MINTEZOL<sup>®</sup> (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



## Dean's Page

### Sir William Osler Revisited

DONN L. SMITH, M.D.

In our current culture as it relates to Medicine, its practice, its educational enterprises and to medical research, there is much confusion, and some not inconsiderable stress and strain.

With all of the three above named parts of modern medicine under heavy assault from the public, politicians, the Washington bureaucracy and others, it is sometimes difficult to achieve the necessary reinforcement of motivation. Working in these areas of medicine requires dedication and purposeful expenditure of large amounts of physical and intellectual effort over long periods of time. The continuous utilization of inner resource which must result leads to the need for periodic stimuli, of which reasonably frequent points of reinforcement is one.

It is on occasion stimulating and provides a feeling of useful endeavor to review the lives of some of our more illustrious predecessors, and to note that they were able to rise above and go beyond incidents and times of trial and trauma.

One of the most fruitful careers in medicine to survey is that of Sir William Osler. He was, in his time, a giant in practice, teaching and research. The accomplishments and the style of Osler's contributions provide a superb model for the modern physician as well as a clear and refreshing well spring for the maintenance and furtherance of one's equanimity as well as a potential philosophical reinforcement of devotion to duty and compassion for other human beings.

There are several fascinating books available which provide a significant review of the man as a person, his attainments in medicine, and some of the obstacles and problems to which Dr. Osler

was exposed. The *LIFE OF SIR WILLIAM OSLER*, by Harvey Cushing, published in 1924 and reprinted in 1940 by the Oxford University Press is an exciting and revealing text in two volumes. Another excellent book is the *SIR WILLIAM OSLER, MEMORIAL VOLUME*, privately issued in 1926 in Montreal with an exquisite foreword by William Welch. A two volume production entitled, *CONTRIBUTIONS TO MEDICAL AND BIOLOGICAL RESEARCH* dedicated to Sir William Osler by his pupils and co-workers, published in 1919 by Paul B. Hoeber, is a collection of papers by most of the eminent medical people of the day. This represents an instructive and significant glimpse of the scientific milieu in which Dr. Osler worked. And last but no means least, is Osler's own *AEQUANIMITAS*, published in 1904 in Philadelphia.

A few minutes spent in perusal of these tomes can be an illuminating and inspirational experience for all of us engaged in any part of the medical profession.

For me, the essence of the man, for whom I have so obvious an admiration dwells in his statement: "Engrossed late and soon in professional cares, getting and spending, you may so lay waste your powers that you may find, too late, with hearts given away, that there is no place in your habit-stricken souls for those gentler influences which make life worth living."

If you on some occasion seriously wonder if it is all worthwhile, beset by problems and doubts, it may be a useful thing to revisit the life and times of that most remarkable physician, Sir William Osler.

► Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

# The Rx that says "Relax"

**BUTISOL Sodium provides highly predictable sedative effect:** minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

**BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action:** begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

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These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

\*Based on surveys of average daily prescription costs.



**Butisol** SODIUM  
(SODIUM BUTABARBITAL)

**Contraindications:** Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics.

**Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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### PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

**Precautions.** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

**How Supplied.** Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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New York, New York 10017

# Clean Sweep



## with a single dose of Antiminth

(pyrantel pamoate) ORAL SUSPENSION

Highly effective against  
pinworm and roundworm

Non-staining to teeth  
or oral mucosa on ingestion, to  
tools, clothing, linen

Simple dosage with a  
single-dose regimen: 1 cc. per  
10-lb. body weight (1 tsp./50 lb.;  
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clinical studies\*

Pleasant-tasting, easy-to-  
take, caramel-flavored oral  
suspension

Economical, because one  
prescription can treat the entire  
family

**ROERIG** *Pfizer*

A division of Pfizer Pharmaceuticals  
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# ANTIMINTH<sup>®</sup>

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

While Antiminth is highly effective against pinworms and roundworms, the illustration is not meant to imply 100% efficacy.

\*Data on file at Roerig.

Please see prescribing information on facing page.



# What's on your patient's face...

may be more important than  
his chief complaint

The lesions on his face may be solar/actinic — so-called "senile" keratoses...and they may be premalignant.

## Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



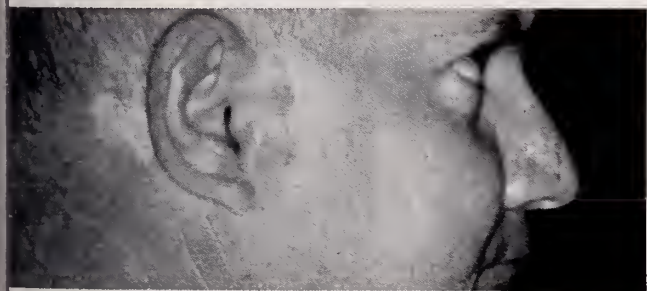
*Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electro-surgical procedures.*

## Sequence of therapy/ selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; the reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

## Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.



*Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5%-FU cream. Reaction has subsided. Residual scarring not seen except for that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.*

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local — pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported — insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with non-metal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers — containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes — containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

This patient's lesions  
were resolved with

**Efudex®**  
**(fluorouracil)**  
5% cream/solution  
...a Roche exclusive



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



## **Medical News**

### **Dr. Davies Promoted at Miami U.**

John E. Davies, M.D., Associate Professor of Medicine at the University of Miami School of Medicine, has been named Chairman of the Department of Epidemiology and Public Health.

A member of the faculty since 1962, Dr. Davies is a member of the Florida Medical Association. He has been serving as Director of the federally-sponsored Community Pesticides Studies in the Miami area.

### **Family Planning Seminar in Jax**

The American College of Obstetricians and Gynecologists is conducting a series of tuition-free seminars in family planning for family practice physicians and interested specialists in Jacksonville.

One such seminar having been held in March. Other meetings in Jacksonville will be April 26-27, May 28-29, and June 25-26.

Information may be obtained from Jules M. Terry, M.D., Emory University Dept. of Ob.-Gyn., Hartford Insurance Building, 100 Edgewood Avenue, Room 805, Atlanta, Georgia 30303.

### **Accelerated Curriculum at Miami**

The University of Miami School of Medicine will introduce an accelerated curriculum this year. First-year students will begin in July instead of September and will remain in school for 33 months rather than the standard 36-month program spread over four years. Dean Emanuel M. Papper, M.D., said the new program is consistent with a national pattern in medical education and the quality of the program will not be affected. The School has 124 students lined up for the first three-year curriculum.

### **Orlando M.D. Named to BME**

Gov. Reubin Askew has appointed Benjamin M. Cole, M.D., of Orlando, to the Florida State Board of Medical Examiners. He succeeds Courtlandt D. Berry, M.D., of Naples, who resigned.

A member of the Orange County Medical Society and the Florida Medical Association, Dr. Cole is Chief of Staff of Orange Memorial Hospital.

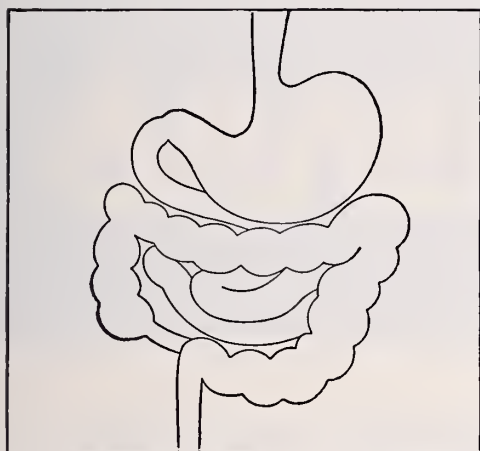
### **ENT Diplomate**

Jerry A. Margolin, M.D., of Clearwater, has been certified as a Diplomate of the American Board of Otorhinolaryngology. He is a member of the Pinellas County Medical Society and the Florida Medical Association.

### **New Nursing Dean at Florida**

Blanche I. Urey, Ed.D., has been appointed Dean of the University of Florida College of Nursing, succeeding Miss Dorothy M. Smith, who retired. Dr. Urey has been Assistant Dean and Associate Professor of Nursing at the Medical University of South Carolina since 1969.

# in “Gasspastic” conditions



The GI tract in spasm is commonly a “gas trap.”

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that “lyses” gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gastritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

**Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.**

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Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

## can do more

**Contraindications:** Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.

**Side Effects:** Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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*optional  
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# FEEDBACK -from Pearl Street

## Was it the Flu, Or What?

One way to emphasize the relatively nonspecific symptoms presented by virus diseases is to allow the brilliant, clear unforgiving light of the retrospectroscope to shine on data obtained by the Virus Unit of the State Bureau of Laboratories. In January and February this laboratory tested over 260 sets of paired sera submitted by private physicians and county health departments for confirmation of clinical diagnoses of respiratory disease. The sample is biased since virtually all of the serum came from the patients with typical influenza-like disease (headache, fever, nonproductive cough and severe myalgias of several days duration). Interestingly, influenza A virus caused only 16% of these illnesses. A few scattered cases of adenovirus infection along with several cases of *Mycoplasma pneumoniae* and parainfluenza I infection were documented. No influenza B infections were found. The highest rate of influenza A infections apparently occurred during the last week in January; convalescent sera run two weeks later showed 36% positive for influenza A.

No diagnosis was confirmed in almost 80% of serum samples submitted. It is assumed that the majority of these represent various rhinovirus or other infections of the "common cold" type.

Influenza A is associated with excess mortality in persons already chronically ill with some other disease, but its clinical manifestations are indistinguishable from those produced by a multitude of other respiratory virus agents. When influenza A is present in the community, a fair proportion of patients presenting with acute respiratory disease will have influenza A disease. When the virus is not circulating to any great extent, then the vast majority of patients with respiratory ailments will probably have rhinovirus or other non-influenza infection.

We did have a fair amount of influenza in Florida this flu season but we did not have the excess mortality experienced by many other states. We did not have epidemic-type transmission. Virtually all our cases of influenza A were caused by virus strains to or indistinguishable from A/England/42/72—the so-called "London flu."

## Family Planning

Family planning is a Division of Health priority program. Florida leads the eight state Region IV in provision of these services through county health departments. The National and Regional Centers for Family Planning state that the program is the most comprehensive in the nation. New day and night clinics have more than tripled over the past three years. In 1973 well over 40% of the target population should be reached.

The initial clinic visit includes (1) a complete history and physical examination with the teaching of breast self-examination; (2) hemogram, urinalysis, VDRL, cultures for GC and a Pap smear; (3) counseling in the areas of sex, fertility-infertility, premarital information, sterilization, sex and the law, venereal diseases and genetics, and (4) family planning with appropriate supplies and/or methods provided and instructions for use.

## Immunizations—School Enterers

Data are available for the second school year since the immunization law was passed. Of almost 200,000 children enrolled, close to 82% were immunized against diphtheria, pertussis, tetanus, polio, measles and rubella. An additional 11% had individual medical exemptions, indicating primarily the need of a booster or one additional vaccine for full immunization. Only 237 children requested exemption on religious grounds. These data reflect tremendous effort on the part of private physicians, health departments and schools to comply with the letter and spirit of the law. There is room for improvement though, and a more widespread use of the Certificate of Immunization (Form PD-137) would help to insure an even better record next year.

If we continue to achieve high immunization levels for virtually all of the school enterers, the occurrence of these vaccine preventable diseases and their resultant sequelae and costs should be virtually eliminated in elementary schools in the near future. Indeed, the current year is unique among recent past years in the absence of reported measles outbreaks in elementary schools.

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## Bacterial Meningitis in Infants

RONG-GONG LIN, M.D. AND JAMES C. LANIER, M.D.

**Abstract:** This is a study of bacterial meningitis occurring in infants under one year of age at the three private hospitals in Jacksonville, Florida during a ten year period. Clinical signs and symptoms are evaluated as well as the laboratory aids in diagnosis. The relative importance of certain bacteria as a cause of meningitis is shown to vary with age of the patient as well as with the season of the year. Mortality rates are discussed and therapeutic measures evaluated.

Eighty infants admitted to Baptist Memorial Hospital, St. Luke's Hospital and St. Vincent's Hospital in Jacksonville, Florida, from 1962 to 1972 with the diagnosis of bacterial meningitis were studied regarding several factors relating to mortality and morbidity and prognosis. These included etiology, age at onset, sex, season, clinical findings, laboratory findings, type of antimicrobial therapy administered, persistence of fever after admission, presence or absence of subdural effusion, survival and autopsy findings.

The records were examined of infants who had a diagnosis of meningitis indicated on hospital charts and autopsy files. Only those with onset of illness under one year of age and who also satisfied certain laboratory criteria and/or had autopsy evidence of purulent meningitis were included. At least two of four positive results of laboratory tests were required: (1) positive spinal fluid culture; (2) spinal fluid pleocytosis ( $>20$  cells with a predominance of polymorphonuclear

forms); (3) decreased spinal sugar ( $<40$  mg.% or less than 50% of a simultaneously obtained blood sugar), and (4) definite bacteria on a stained smear of the spinal fluid.

### Etiologic Agent

Studies reported in Table 1 identify the etiologic agent found. All causative organisms were cultured from the spinal fluid except the paracolon bacilli which was obtained from meninges at autopsy.

For the purpose of this study, patients with a diagnosis of bacterial meningitis of undetermined cause included all with negative cerebral spinal fluid cultures for bacteria, but with cell count,

TABLE 1.—ETIOLOGIC AGENT AND THE MORTALITY RATE OF INFANTS UNDER ONE YEAR OF AGE WITH BACTERIAL MENINGITIS.

Organism	No.*	%	Mortality+ Rate (%)	
Hemophilus influenzae	34/80	42.50%	1/34	2.94%
Undetermined	15/80	18.75%	3/15	20.00%
Enteric bacteria	9/80	11.25%	3/9	33.33%
Escherichia coli	4/80	5.00%	1/4	25.00%
Pseudomonas aeruginosa	2/80	2.50%	1/2	50.00%
Klebsiella	1/80	1.25%	0/1	0
Coliform bacilli	1/80	1.25%	0/1	0
Paracolon bacilli	1/80	1.25%	0/1	100 %
Streptococcus (one gamma, seven beta hemolytic)	8/80	10.00%	0/8	0
Pneumococcus	7/80	8.75%	1/7	14.28%
Meningococcus	5/80	6.25%	0/5	0
Staphylococcus (positive coagulase)	1/80	1.25%	0/1	0
Tubercle bacillus	1/80	1.25%	0/1	0

\*Denominator=Total number of patients.  
+Total mortality rate of 8/80 was 10%.



differential, glucose and protein determination consistent with the diagnosis.

The most common organism of bacterial meningitis found in infants was *H. influenzae*, undetermined cause ranked second; enteric bacteria third; streptococcus fourth; pneumococcus fifth, and meningococcus, sixth.

Nineteen of 80 patients were infants under 28 days of life. Figure 1 shows the ratio between neonates and other infants under one year of age.

The relative incidence of neonatal bacterial meningitis according to etiology is shown in Table 2. The most common causative organisms found were streptococcus and enteric organisms.

This study showed an overall mortality rate of 10%. The mortality rate of neonatal bacterial meningitis was 26.31%.

The mortality of the patients with enteric bacterial meningitis was high, whereas none died from streptococcal or meningococcal meningitis.

#### Age at Onset

The incidence and mortality are shown in relation to age in Figure 2.

Neonates under 28 days of age had a high incidence and mortality which was shown in Table 2 and Figure 2. *H. influenzae* meningitis was the most prevalent at the age of six to ten months (Fig. 2). No instance with *H. influenzae* meningitis was found in the neonatal period.

Meningitis due to streptococcus showed the most striking incidence relative to age, with 75% of all cases occurring in neonates under 28 days of age and none above two months of age; none died.

Surveying the patients with enteric bacterial meningitis, all were found to be under the age of five months. The overall mortality rate was 33.33%, and 77.77% were under 28 days old and had a mortality rate of 42.86%, showing that as the age at onset increased the mortality rate decreased.

Three of seven pneumococcal meningitis cases (42.86%) occurred in patients at the age of nine months. One died at the age of seven months.

There was one instance each of tubercle bacillus meningitis and staphylococcal meningitis, both patients were eight months old and both survived.

#### Sex

The number of males with bacterial meningitis slightly outnumbered females. Five of eight deaths

were among males. The number of instances of females and males due to each *H. influenzae* and streptococcal meningitis were equal. Males predominated in meningococcal meningitis. The females with enteric bacterial meningitis had a greater number but the mortality rate was the same in both sexes. There was one instance each of staphylococcal and tubercle bacillus meningitis; both were male. (Fig. 3).

#### Season

The incidence and mortality of bacterial meningitis is shown in relation to the season in Figure 4. Meningitis due to *H. influenzae* showed a striking seasonal variation with most cases occurring in the spring and fall. Pneumococcal meningitis was most prevalent in winter, whereas most en-

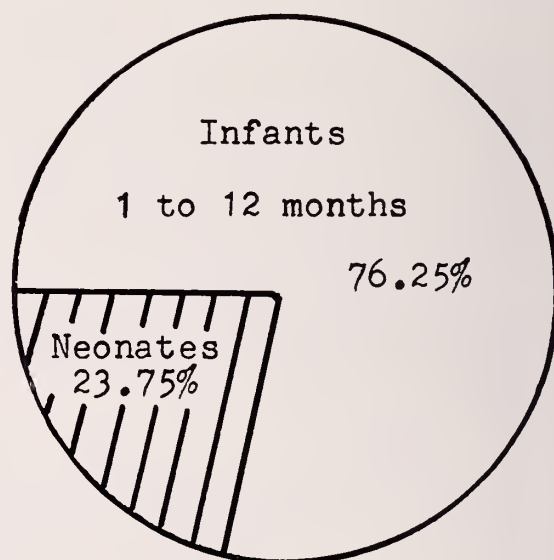


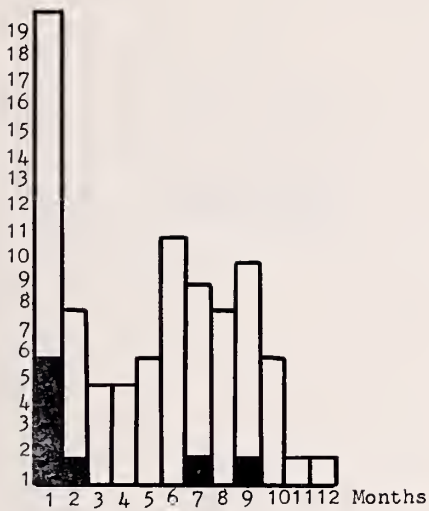
Fig. 1.—The ratio of bacterial meningitis in neonates and other infants under one year of age.

TABLE 2.—ETIOLOGIC AGENT AND MORTALITY RATE OF NEONATAL MENINGITIS.

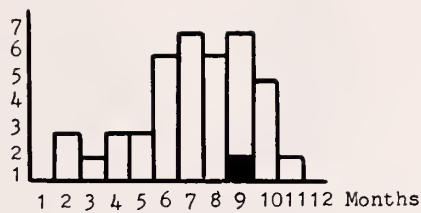
Organism	No.*	%	Mortality+ Rate (%)	
Enteric bacteria	7/19	36.83%	3/7	42.86%
Escherichia coli	3/19	15.79%	1/3	33.33%
Pseudomonas aeruginosa	2/19	10.52%	1/2	50.00%
Paracolon bacilli	1/19	5.26%	1/1	100%
Coliform bacilli	1/19	5.26%	0/1	0
Streptococcus (five beta hemolytic, one gamma)	6/19	31.58%	0/0	0
Undetermined	3/19	15.79%	2/3	66.67%
Pneumococcus	2/19	10.52%	0/2	0
Meningococcus	1/19	5.26%	0/1	0

\*D-nominator=Total number of neonates.  
+Total mortality rate of 5/19 was 26.31%.

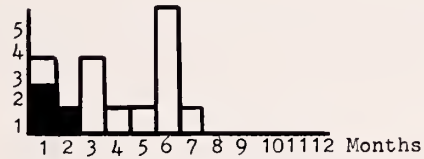
# Cases



Total (80 cases)



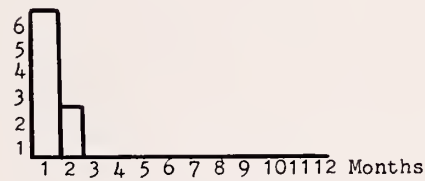
H. Influenzae (34 cases)



Undetermined (15 cases)



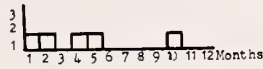
Enteric Bacteria (9 cases)



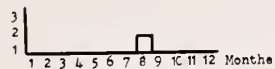
Streptococcus (8 cases)



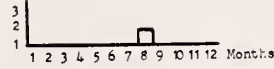
Pneumococcus (7 cases)



Meningococcus (5 cases)



Staphylococcus (1 case)



Tubercle bacillus (1 case)

□ Total cases

■ Deaths

Fig. 2.—Incidence and mortality in patients with bacterial meningitis according to age.

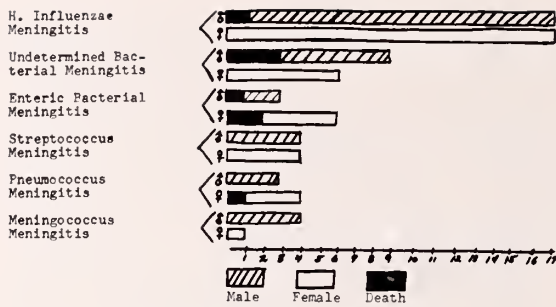


Fig. 3.—Incidence and mortality in patients with bacterial meningitis according to sex.

teric bacterial meningitis was found in the summer. The disease occurred throughout the year with slight increase noted in the spring and in the late fall.

### Clinical Findings

The most common presenting symptoms were irritability, refusing to feed, fever and drowsiness. The most common presenting signs were bulging fontanel and stiff neck. Other neurologic signs were coma, convulsion and opisthotonos. Forty-two of 80 patients (52%) had convulsions. Some infants were pale and dusky and showed respiratory distress.

On occasion the cardinal signs were absent. Three patients had hypothermia. Two with streptococcal meningitis had no bulging fontanel. Four patients had a supple neck. Two of these had streptococcal meningitis. One interesting patient with bacterial meningitis, type undetermined, had a supple neck, soft and flat fontanel and hypothermia. He died after 31 hours in the hospital.

Seven of 80 patients (8.75%) with bacterial meningitis had otitis media on admission. Three of seven patients with otitis media had H. influenzae meningitis. Three patients with type undetermined bacterial meningitis had otitis media. Only one instance with pneumococcal meningitis had otitis media.

Two patients with meningococcal meningitis had petechiae. Two patients with Pseudomonas meningitis and one patient with Klebsiella meningitis had hydrocephalus.

The relationship between severity of illness on admission to mortality is shown in Table 3. Thirty-five per cent of all cases presented in semicoma and coma. Alteration of the state of

consciousness to this degree was associated with 21.5% mortality, whereas the mortality rate of those still lucid on admission was only 3.98%.

### Laboratory Findings

Cerebrospinal fluid from 79 patients was examined, lumbar fluid from 76 and ventricular fluid from three. The white blood cell count in the fluid ranged from 54 to 33,600 cells per mm.<sup>3</sup> Most of the differential counts demonstrated a polymorphonuclear predominance. Sixty-one cerebrospinal fluid protein determinations revealed a range of 16 to 1,350 mg.%, most being 100 to 400 mg.%, only two being below 20 mg.% (one instance was pneumococcal meningitis, another was H. influenzae meningitis). Thirty-six of 55 (65.45%) cerebrospinal fluid sugars were below 40 mg.%; in five the sugar was absent. In 31 of 53 smears (60%) bacterial organisms were demonstrated. Organisms were recovered in 65 of 80 (80%) cerebrospinal fluid specimens cultured. The etiologic agent of one patient was recovered from culture obtained at autopsy.

Blood cultures were positive for the same organism isolated from the cerebrospinal fluid in 22 of 34 obtained (64.7%). It was 71.43% in the neonates with bacterial meningitis, 92.3% in the patients with H. influenzae meningitis and 66.67% in those patients with streptococcal meningitis.

Peripheral blood white cells counts ranged

TABLE 3.—MORTALITY IN PATIENTS WITH BACTERIAL MENINGITIS ACCORDING TO SEVERITY OF ILLNESS ON ADMISSION.

Severity of Illness	No. Cases	Death	%Mortality
Mild	1	0	0
Moderate (lethargy)	51	2	3.98%
Severe (semicoma-coma)	28	6	21.50%

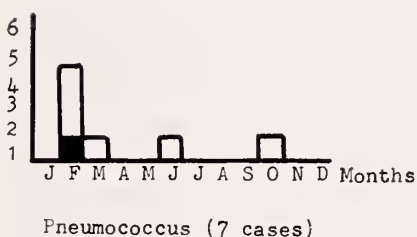
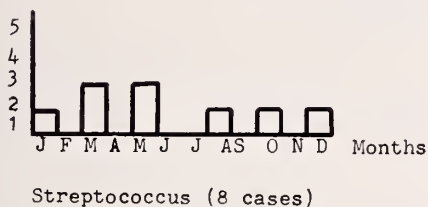
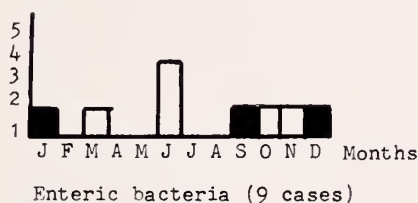
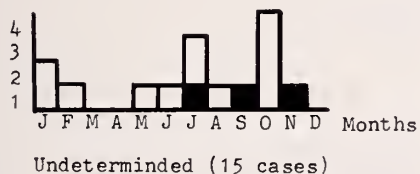
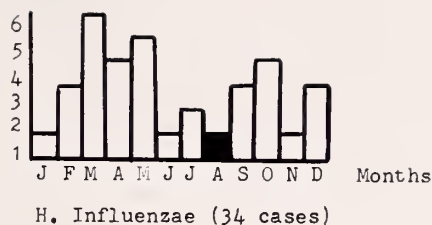
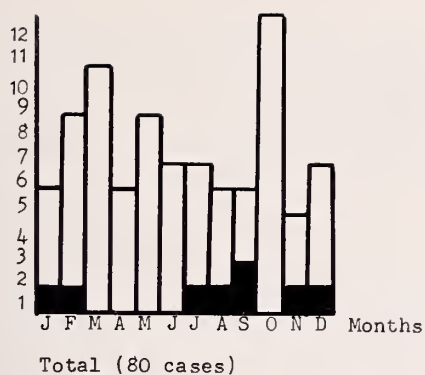
TABLE 4.—DURATION OF FEVER IN BACTERIAL MENINGITIS.\*

Etiology	Number of cases	Mean (days)	Extremes (days)
H. influenzae	26	7.5	3-14
Undetermined	8	5.5	1-21
Streptococcus	6	5.5	3-7
Meningococcus	4	5.5	2-11
Pneumococcus	3	4.7	2-10
Staphylococcus	1	4	4
E. coli	1	4	4
Tubercle bacillus	1	4	4
Pseudomonas	1	7	7
Klebsiella	1	10	10
Total**	52	5.9	

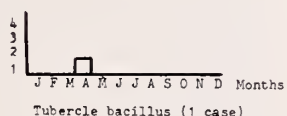
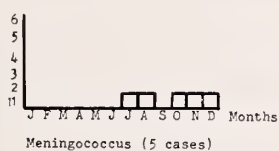
\*Persistent elevation above 100 F.

\*\*Data not available on all 80 patients.





#### SEASON



#### SEASON

□ Total cases

■ Deaths

Fig. 4.—Incidence and mortality in patients with bacterial meningitis according to season.

from 3,900 to 36,900 per cubic millimeter with variable differentials.

#### Survival Time After Admission

Of all patients who died 37.5% did so during the first 24 hours after admission and 62.5% of all deaths occurred within 48 hours of admission. Two deaths occurred during the first 12 hours of hospitalization. One patient had paracolon bacilli meningitis, the other pneumococcal meningitis. Three deaths occurred after five days of admission. One patient died after one month and 19 days of hospitalization with *Pseudomonas* meningitis. Survival for more than two days after treatment was initiated appeared to be a favorable prognostic sign and by this period of time improvement was evident in most of those patients who survived.

#### Persistence of Fever After Admission

Duration of fever after antimicrobial therapy was instituted is shown in Table 4. Patients who were hypothermic on admission, or who died shortly after admission are not included in this table.

The mean duration of fever for all study groups was 5.9 days. Patients with *H. influenzae* meningitis had fever for 7.5 days after therapy was initiated. Those patients with streptococcal or meningococcal or type undetermined bacterial meningitis had fever for 5.5 days. Fever was less protracted in patients with pneumococcal meningitis. The duration of fever in patients with the following types of meningitis were too rare in occurrence to compare: staphylococcal, *E. coli*, *Pseudomonas*, *Klebsiella*, and tubercle bacillus.

#### Type of Antimicrobial Therapy Administered

Table 5 summarizes the result of the choice of

TABLE 5.—THE SPECTRUM OF DRUGS  
USED IN THE TREATMENT OF BACTERIAL  
MENINGITIS.

The Choice of Drugs	Number of Cases*	%	Number of Deaths
<b>H. INFLUENZAE MENINGITIS</b>			
Ampicillin alone	11/34	32.35%	0
Penicillin + chloramphenicol	8/34	23.53%	0
Penicillin + chloramphenicol + sulfadiazine or sulfisoxazole	8/34	23.53%	0
Chloramphenicol + ampicillin + sulfadiazine or sulfisoxazole	4/34	12.76%	0
Ampicillin + penicillin	1/34	2.94%	0
Chloramphenicol + streptomycin + sulfadiazine	1/34	2.94%	1
Chloramphenicol alone	1/34	2.94%	0

#### STREPTOCOCCUS MENINGITIS

Penicillin alone	5/8	62.5 %	0
Penicillin + chloramphenicol + sulfadiazine or sulfisoxazole	2/8	25 %	0
Penicillin + ampicillin	1/8	12.5 %	0

#### PNEUMOCOCCUS MENINGITIS

The Choice of Drugs	Number of Cases*	%	Number of Deaths
Penicillin + chloramphenicol + sulfadiazine or sulfisoxazole	4/7	57.14%	0
Penicillin alone	1/7	14.28%	0
Penicillin + ampicillin	1/7	14.28%	1
Cephaloridine	1/7	14.28%	0

#### MENINGOCOCCUS MENINGITIS

Penicillin + chloramphenicol + sulfadiazine or sulfisoxazole	5/5	100%	0
--	-----	------	---

#### E. COLI MENINGITIS

Penicillin + chloramphenicol + sulfadiazine or sulfisoxazole	2/4	50%	1
Ampicillin alone	1/4	25%	0
Ampicillin + kanamycin	1/4	25%	0

#### COLIFORM BACILLI MENINGITIS

Penicillin + chloramphenicol + streptomycin	1/1	100%	0
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#### PSEUDOMONAS MENINGITIS

Colistin + tetracycline	1/2	50%	0
Colistin + chloramphenicol	1/2	50%	1

#### KLEBSIELLA MENINGITIS

Ampicillin + kanamycin	1/1	100%	0
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#### TUBERCLE BACILLUS MENINGITIS

Streptomycin + INH + PAS	1/1	100%	0
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#### STAPHYLOCOCCUS MENINGITIS

Ampicillin	1/1	100%	0
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#### UNDETERMINED BACTERIAL MENINGITIS

Penicillin + chloramphenicol + sulfadiazine or sulfisoxazole	8/15	53.33%	1
Ampicillin alone	2/15	13.33%	0
Penicillin + chloramphenicol + streptomycin	1/15	6.67%	1
Penicillin + chloramphenicol	1/15	6.67%	0
Penicillin + kanamycin + chloramphenicol + streptomycin	1/15	6.67%	1
Ampicillin + kanamycin	1/15	6.67%	0
Ampicillin + kanamycin + penicillin + chloramphenicol + sulfadiazine	1/15	6.67%	0

\*D-nominator=Total number of patients.

drugs in the antimicrobial therapy of bacterial meningitis. Most of our patients received a combination of antimicrobial drugs. In some patients, drugs were quickly changed as the definite identification of the causative organism was made or the patient's condition changed. These drugs were not included in this report.

Nearly one third of the cases of *H. influenzae* meningitis (11 of 34 or 32.35%) were treated with ampicillin alone, and 23.53% were on penicillin with chloramphenicol and an equal per cent were treated with a combination of penicillin, chloramphenicol and sulfadiazine or sulfisoxazole. Four patients received chloramphenicol, ampicillin and sulfadiazine or sulfisoxazole. One patient received ampicillin and penicillin. One patient was treated with a combination of chloramphenicol, streptomycin and sulfadiazine and the remaining patient was treated with chloramphenicol alone.

Five of eight patients with streptococcal meningitis were treated with penicillin alone. Two received a combination of penicillin, chloramphenicol and sulfadiazine or sulfisoxazole; one received penicillin with ampicillin.

More than half the patients with pneumococcal meningitis were treated with a combination of penicillin, chloramphenicol and sulfadiazine or sulfisoxazole. One was treated with both penicillin and ampicillin. The remaining patients were treated with only one medicine, that being either penicillin alone or cephaloridine alone.

All five patients with meningococcal meningitis were treated with a combination of penicillin, chloramphenicol and sulfadiazine or sulfisoxazole.

Two patients with *E. coli* meningitis received penicillin with chloramphenicol and sulfadiazine or sulfisoxazole. One was treated with a combination of ampicillin and kanamycin. One was on ampicillin alone.

The only patient with *Coliform* bacilli meningitis was treated with a combination of chloramphenicol, streptomycin and penicillin.

Two patients with *Pseudomonas* meningitis were treated with double drugs, that being either colistin with tetracycline, or colistin with chloramphenicol.

One patient with tubercle bacillus meningitis was treated with a combination of streptomycin, INH and PAS. The patient with staphylococcal meningitis received ampicillin alone.

One patient with *Klebsiella* meningitis was treated with ampicillin and kanamycin.

One patient in which a culture of paracolon

bacilli was obtained from the meninges at autopsy did not receive any antimicrobial drugs.

The type of antimicrobial drugs for those patients with undetermined bacterial meningitis were varied (Table 5).

### Subdural Effusion

Subdural taps were done only on patients who developed persistent fever, irritability, vomiting, distended fontanel, enlarging head size, spreading of the cranial sutures noted on skull roentgenogram or transillumination findings which suggested subdural effusion.

The total cases of subdural effusion in bacterial meningitis were nine. Seven of the nine (77.77%) had *H. influenzae* meningitis, one died. Another patient had a type of undetermined bacterial meningitis. One had meningococcal meningitis.

The mean age of those patients with *H. influenzae* meningitis and subdural effusion was 6.7 months with a range of two months through nine months.

### Autopsy Findings

Autopsies were performed on six of the eight patients; each of the six had evidence of purulent meningitis. Two had intracranial hemorrhage; one of them had massive subarachnoid and intracerebral hemorrhage; the other had a pontine hemorrhage and also a perforated duodenal ulcer.

The common site of infection outside the central nervous system was the lungs; pneumonitis being present in two cases. Other sites of infection included peritonitis in one, otitis media in one, and enterocolitis in one.

### Discussion

Twenty-three percent of bacterial meningitis in infants occurs in the neonate. The mortality of neonatal bacterial meningitis was high (26%) as compared to those over 28 days of age (5%). The streptococcus and enteric bacteria were the most common cause of neonatal meningitis. No streptococcal meningitis occurred after two months of age. Seventy-seven percent of enteric bacterial meningitis occurred in neonates and 43% of them died; all occurred before five months.

Knowledge of conditions predisposing to the development of infection in the newborn infant is important. It is reported that difficult traumatic delivery may result in a break in the normal skin and mucous membrane barriers to infection.<sup>1</sup> It is also reported that premature rupture of the membranes when occurring together with maternal



peripartum infection and/or chorioamnionitis also seemed to contribute to the development of neonatal bacterial meningitis.<sup>2</sup> Initial infection of the upper and lower respiratory tract and other sites in the infant were important in acting as a portal of entry for the subsequent development of meningitis.

The importance of septicemia as a factor in the pathogenesis of meningitis is substantiated by the frequent occurrence of positive blood cultures. In this study, 65% of the blood cultures were positive. Particularly with *H. influenzae* was the blood culture important; it was positive in 92% of those cultured.

In *H. influenzae*, the peak of occurrence was ten months of age. It was the most common causative organism of bacterial meningitis in infants in this study. Some cases were preceded or accompanied by an infection of the upper respiratory tract or otitis media. More occurred in the spring and fall. An increase in neurologic sequelae in survivors was seen with prolonged illness in patients with *H. influenzae* meningitis. Subdural effusion was the most frequent complication, occurring nine times. Seven of these patients had *H. influenzae* meningitis. The presence of subdural effusions in this study, however, showed no relationship to mortality or the incidence of gross neurologic sequelae in survivors. One instance with *H. influenzae* meningitis had cranial nerve signs which consisted of facial palsy and oculomotor nerve palsy.

Other complications included three patients with hydrocephalus. One of them died. One of the survivors had cerebral palsy (spastic type); another had paraplegia.

The incidence, morbidity and mortality seemed not to be influenced by the sex of the patient.

The choice of drugs for an individual with meningitis depended on the bacteriologic identification of the organism, though age and concomitant diseases were important in the choice of initial chemotherapy.

During the course of the ten years studied, the trend in treatment changed. From 1962 to 1964, the majority of patients were treated with a combination of penicillin, chloramphenicol and sulfadiazine or sulfisoxazole. In 1965 to 1968, the triple drug and double drug therapy were used for all types of meningitis, except *H. influenzae* and streptococcal, in which a single drug was used. By the period 1969 to 1972, a single drug was found to give the most effective treatment, as soon

as the etiologic agent was identified.

Most *H. influenzae* were sensitive to ampicillin and chloramphenicol by the disc method. All results from routine disc sensitivity testing of *Pneumococcus*, *Meningococcus* and *Streptococcus* were reported as "sensitive to penicillin."

It is important to emphasize that routine disc susceptibility testing of *H. influenzae*, type B, against ampicillin may yield misleading results. In one study, *H. influenzae*, type B, strains reported as "resistant" by the disc technique but were invariably susceptible when tested by tube dilution.<sup>3</sup> In this study, two instances with *H. influenzae* reported as "resistant to ampicillin" by the disc technique were treated, nevertheless, with ampicillin alone; both patients recovered.

In this study, six of eight deaths had no antimicrobial therapy before admission to the hospital.

Rapid onset of symptoms with hospitalization in the first 24 hours has been shown by some to be associated with a grave prognosis.<sup>4</sup> No conclusion could be drawn in this regard in this study.

Fever, bulging fontanel, stiff neck, and convulsions were the most common presenting signs. On occasion, these cardinal signs were absent. A reduced state of consciousness on initial examination was accompanied by an increased mortality rate. Survival for two days is a good prognostic sign. Fever persisted five to seven days after antibiotic therapy was started.

The CSF findings were as expected. Smear and culture demonstrated the organism 60% to 80% of the time.

### Conclusion

Analysis of 80 patients with bacterial meningitis has shown several significant factors related to diagnosis, therapy and prognosis. Knowledge of the causative organism and its antimicrobial sensitivity pattern is of considerable aid in therapy of patients who have bacterial meningitis early in life.

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# Pulmonary Function Single Breath Testing

## A One Month Study

THOMAS E. DALY, M.D.

**Abstract:** Florida's "over 65" population exceeds the national estimate by about 5%; the State has a great number (1,000,000) of elderly persons within its borders, and they naturally exhibit the usual degenerative physiological and pathological changes common to advanced age.

Our department's concern here at St. Mary's Hospital, West Palm Beach, is to establish ways and means of detecting and instituting treatment of the chronic lung disease so prevalent in this age group. We do not believe that these people, or their lung ailments, should be relegated to a place of secondary importance.

During admission, we routinely use a single breath pulmonary test; for simplicity's sake we only concern ourselves with a single volumetric parameter (the very reliable Forced Exhalation Volume/ per 1.0 second, or for brevity  $FEV_{1.0}$ ). This value shows us that we have a 60% day in and day out respiratory involvement situation.

The method, results, and course of events leading up to the adoption of this test as part of our admission procedures are discussed.

Census figures show that Florida has more residents over 45 years of age, 37%, than is the case for the United States as a whole. About 15% of the state's population is 65 years of age compared to a national estimate of approximately 10%.

In this land of sunshine and balmy breezes, the death rate figures for chronic lung disease (C.L.D.) climbs inexorably—the 21.3 per 100,000 in Florida outstrips the national figure of 15.6 per 100,000.

Three problems confront those who wish to engage in the fight against this insidious foe; (1) detection, (2) availability of helpful statistical material dealing with the incidence of the C.L.D. triumvirate, asthma, emphysema and chronic bronchitis, and (3) shortage of properly trained personnel for both hospital and home care.

This report is concerned with the problem of detection.

### Detection

St. Mary's Hospital has 235 beds and a high admission rate in elderly persons—60% of daily admissions are 65 years of age and over. We perform a great many IPPB treatments based mainly on symptomatology and intuition. The general feeling of the staff is that a more scientific approach in the ordering of these procedures would be welcomed. Our position, therefore, was one of needing a rapid accurate method of uncovering abnormalities in pulmonary activity, even when these existed only to a minor degree. It would be desirable to do this while putting the patient to a minimum of exertion and, at the same time, not overly increasing the work of an already over-taxed staff.

It was quite evident that, in the interest of speed, we would have to decide, if possible, on a single parameter for our purpose. An arbitrary constant seemed to be the one in widespread use by a great many investigators and designated as  $FEV_{1.0}$  (Forced Expiratory Volume/1.0 second). This time volume spirometric determination correlates very well with impaired lung function and pulmonary disability of all types.

A search for a recording apparatus was the next order of business. We discovered a number of interesting instruments in the blue print stage and prototypes of others that cannot be had as yet. We were limited in choice but were able to borrow the equipment which we thought was the best. This instrument employs a computer which reads out and prints out the results. An XYZ re-

Dr. Daly is Chief of the Inhalation Therapy and Pulmonary Function Department at St. Mary's Hospital in West Palm Beach.

The OHIO 2200 SYSTEM consisting of an OHIO 800 Spirometer and an OHIO 1000 Pulmo-Digi-Comp. was loaned to St. Mary's Hospital for this work by Ohio Medical Products of Madison, Wisconsin.

corder furnishes a flow curve on 8½" x 11" graph paper that can be entered in the patient's chart. All this is done in a matter of seconds.

The instrument was set up in a small office adjacent to the room where the admission laboratory work is done on ambulatory patients. In this location we were able to test about 50% of all admissions and to get the results (FEV<sub>1.0</sub> and graphic record) into the patient's charts before they were put to bed. There were exceptions however—those patients entering through emergency and by ambulance. All obstetric and pediatric patients coming in were not done at this station but were deferred.

### Results

The chart is divided at 60 years of age into two main groups and these are in turn divided into normal and abnormal subdivisions. The abnormal cases are categorized further into mild, moderate, and severe in the manner shown.

Normal .....	FEV <sub>1.0</sub>	80% and above
Mild Impairment .....	FEV <sub>1.0</sub>	70%-65%
Moderate Impairment .....	FEV <sub>1.0</sub>	64%-50%
Severe Impairment .....	FEV <sub>1.0</sub>	49% or less

Noteworthy: 62% of all tested had abnormal findings.

Group	% Abnormal
30-60	12%
60-90	44%

11.5% of the 238 tested had severe involvement.

The 30-60 age group "severe cases" (there were no severe cases detected in the 20-30 group) showed a 3.4% involvement, almost one half as much as in the older 60-90 category.

Along with the figures a graphic chart containing a time-volume curve was placed in the patient's chart for analysis and for future comparison and reference.

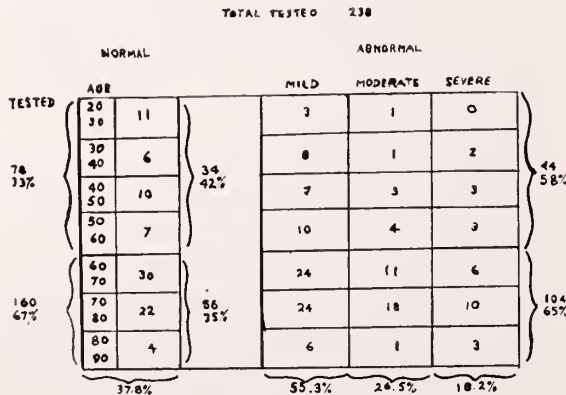


Figure 1

No attempt was made to determine any relationship between involvement and the history of smoking or of past pulmonary disease processes.

### Discussion

The project was designed as a pilot study to determine if the physicians on the staff could avail themselves of a simple test to determine whether a patient did, or did not, have impaired lung function. The figures, admittedly from only a modest sample, were sufficient to provoke a reaction that was quite surprising though not entirely unexpected.

We knew that the idea of permanent testing on admission, or early in the hospital stay, would present many problems but it was evident because of the advanced age of most of the patients, and the inherent incidence of C.L.D. in this age group, that something positive must be done to determine the extent of involvement. It was decided to begin by canvassing the staff members to determine their wishes in the matter.

Stamped and addressed inquiry post cards were mailed to all staff members. An explanation of "what," "why" and "how" went along with the cards. All the physician needed to do was place a check in one of the boxes in front of the three appropriate questions. One question was a negative vote. We asked for a signature where the vote was affirmative but where the thinking was negative the doctor was free to sign or not to sign.

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900 - 45<sup>TH</sup> STREET
WEST PALM BEACH, FLORIDA 33411

☐ TEST MY PATIENTS DURING ADMISSION, ORDER WILL
☐ TEST MY PATIENTS ONLY ON ORDER, AFTER ADMISSION
☐ I AM NOT INTERESTED IN THIS TYPE OF TESTING

SIGNATURE (Not required if you are not interested)

Figure 2

One hundred thirty or a little over 70% of the staff answered. Of this number over 90% were in favor of single breath pulmonary testing of their patients on admission or as soon as would be possible after admission. The most outspoken in praise of the idea were the surgeons, anesthesiologists and Recovery Room personnel.

At the time the cards were out, a committee of the staff made a study of eight of the severe cases which turned up in the work done. The re-



sults left little doubt that a level of involvement existed that hardly anyone was aware of. In some instances the consequences of not knowing the degree of impairment could have been tragic, especially in some surgical cases.

The result of this work, and the study that was made, was an addition to the admission procedure. In the future in this hospital all ambulatory patients over 40 years of age who are to be admitted will be required to have single breath pulmonary function testing done just prior to being put to bed. This will be accomplished at the same time that admission laboratory work is being done. This was put into operation on June 1, 1972.

We believe that this is a significant step to greater detection of and control of respiratory disease. It is our hope also that it might act as an incentive to hospitals, and other health agencies, to employ this, or a similar means, to fight C.L.D.

This article was not submitted as a scientific work but only as a report of the labors and the results of the labors of a dedicated and hard working group of technicians.

► Dr. Daly, St. Mary's Hospital, West Palm Beach 33407.

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## BAC-SI-MY Honor Roll

Following is the BAC-SI-MY\* Honor Roll of Florida physicians who have participated in the Volunteer Physicians for Viet Nam (VPVN) Program:

John H. Beggs, Lake City  
Paul L. Berezney, St. Petersburg  
Irving A. Beychok, Sarasota  
Matthew H. Bradley, Miami Beach  
James J. DeVito, St. Augustine  
James H. Ferguson, Miami  
Gerald M. Hollingsworth, Ft. Walton Beach  
Robert H. Meaders, Pensacola  
Richard E. Perry, St. Petersburg  
Paul L. Schmitz, North Miami  
Elbert J. Soskis, Tampa  
Max Suter, Jacksonville  
Carl M. Voyles, St. Petersburg  
Frederick M. Zerzavy, Jacksonville Beach  
Jose L. Zubero, Jacksonville

The Agency for International Development (AID) has requested the American Medical Association to continue the administration of the VPVN program. 743 physicians have served 940 tours since the inception of the VPVN program in 1965. Approximately 100 volunteers will be required in fiscal year 1973.

\*Bac-Si-My means "American doctor" in Vietnamese.

# A Drug Induced Koro Syndrome

THOMAS W. DOW, M.D., AND DANIEL SILVER, M.D., D.P.M., C.R.C.P.(C)

**Abstract:** Koro is a state of acute anxiety accompanied by depersonalization and the conviction of penile shrinkage. There has been much interest in this entity as an esoteric culture bound syndrome. Recently it has been suggested that there are not really any culture bound reactive syndromes. Koro may just be a variant of

castration anxiety in a susceptible individual. A case is reported of an amphetamine-induced Koro syndrome in a 20 year old Canadian youth which was rapidly controlled with minor tranquilizers and reassurance. The enhanced state of self observation present in many forms of drug intoxication suggests that similar depersonalization states may not be rare.

The term, koro, refers to a state of acute anxiety accompanied by depersonalization and the conviction of penile shrinkage.<sup>1</sup> The psychopathology of this syndrome was first discussed by Van Brero in 1897.<sup>2</sup> Initially, koro was only thought to occur in southeast Asia and among the southern Chinese.<sup>3</sup> However, cases similar to koro have been described among Westerners as far back as Kraepelin in 1921.<sup>4</sup> Van Wulfften-Palthe conceptualized koro in 1934 as an unusual form of anxiety neurosis.<sup>5</sup> Since then, there has been much interest in this nosological entity as one of a number of esoteric culture-bound syndromes.

Recently there has been much controversy in the literature about whether or not there are really any culture-bound reactive syndromes.<sup>6,7</sup> Wittkower feels that there are, but "it would be more appropriate to speak of culture specific variants of psychological reactions or mental disorders also known to occur in other cultures."<sup>8</sup> For example, he sees koro as one variant of the castration anxiety common to Euro-Americans.<sup>9</sup>

Edwards reported the first case of koro in a Western schizophrenic patient<sup>10</sup> while Yap mentioned complaints of penile shrinking in a patient during heroin withdrawal.<sup>1</sup> In a brief case report of koro in a Briton, Yap alludes to another

Englishman taking large quantities of amphetamines who experienced feelings of penile diminution.<sup>11</sup> We believed that the following case was worth reporting since it was documented in detail and because of the current prevalence of drug abuse.

## Case Report

The patient is a 20-year-old adolescent from an upper middle class family. He described an 18-year-old brother as very "straight." He came to the Youth Emergency Service at the Jewish General Hospital complaining of vague aches, discomfort and feelings of depersonalization. He also complained of having a sore penis earlier in the day but became panicky when the feeling developed that his penis was shrinking. He stated that he had taken six tablets of Benzedrine and one tablet of methadone within the preceding 24 hours. He denied any prior drug intake for several days but had a five year history of intermittent use of amphetamines, cannabis products, and LSD. Symptoms had begun six hours prior to coming to the hospital after the last dose of Benzedrine. There was no evidence for any other precipitating factor.

The mental status examination revealed a very anxious young man with increased psychomotor activity who appeared to be tangential in his thinking. His main complaints were concerning feelings of depersonalization, derealization and a shrinking penis. He denied hallucinations or ideas of reference and was well oriented for time, place and person. He showed decreased attention span and concentration and generally poor insight and judgment. The complete physical examination was within normal limits.

Initially, he was given 15 mg. Valium orally and then 10 mg. every four hours for the next 24 hours. After the first dose of Valium and reassurance in the initial interview, his anxiety rapidly decreased as did his feelings of depersonalization and tangential thinking. Within 12 hours, his feelings of penile shrinking had disappeared completely. Follow-up one week and two months later revealed he had not reexperienced feelings of a shrinking penis, although we suspect that he was still a drug abuser. He refused further follow-up contacts.

From the Department of Psychiatry, Jewish General Hospital, Montreal.

Dr. Dow was formerly Resident in Child and Adolescent Psychiatry at the Jewish General Hospital. Dr. Silver is Clinical Director of In-Patient Service and Director of Youth Services there.

## Discussion

Schilder<sup>12</sup> thought enhanced self-observation was a necessary precondition for feelings of depersonalization to occur. This state, of course, is particularly characteristic of many forms of drug intoxication. The phenomenon of feeling bodily changes with hallucinogenic drugs has also been widely described in the literature.<sup>13-15</sup> We suspect that if we were to become more careful in our mental status examinations of patients who present themselves because of drug abuse, we might find that cases similar to the one we have described may not occur as rarely as the literature to date suggests.

A youth may be very reluctant to reveal his source of anxiety to an unknown examiner when it involves the penis. Sedation with an anxiolytic drug, physical examination, reassurance with an explanation of physiological detumescence, and observation until the drug effects and panic abates can successfully carry a youth through a very frightening episode.

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► Dr. Dow, 87 Underwood Street, Orlando 32806.

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For whom a good woman lives,  
To whom his work is a pleasure  
By whom his friends are encouraged  
With whom all are comfortable  
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William Arthur Ward

*Oh Lord, may we always be so inclined to live.*





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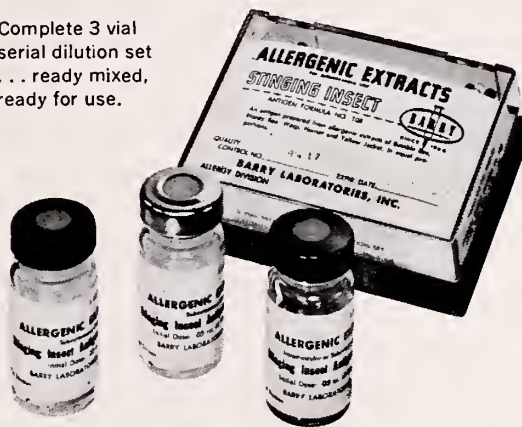
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# Can Compensation Hurt the Sick and Injured? The Active Dependency Syndrome

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**Abstract:** Many persons of a dependent personality type who receive continuing pensions and compensation for disability become chronically depressed and emotionally distressed. Present-day attitudes and practices regarding disability payments tend to perpetuate the dependency of these patients and to interfere with their becoming rehabilitated and developing worthwhile lives for themselves. These practices are discussed in the context of a typical case history and questions are raised as to the potential implications of recent National Health proposals.

Recently a 30-year-old man drove to the hospital from his home in a seaside resort area, where he led a semiretired life of leisure, and asked to be admitted to the psychiatric ward because he feared he would kill himself. Why should this beachboy with a \$10,000 a year tax-free income and no major responsibilities become so extremely depressed?

Physicians observe that retirees and welfare recipients who stopped work become sick, and that college students without clear career and work objectives who receive regular financial support most likely flounder, become depressed, turn to drugs and drop out, and housewives, especially bright ones, who are dependent economically and emotionally on their husbands, are likely to become neurotic. Yet a prime ambition of many people is to retire early, to be idle and dependent for support upon unearned income and for amusement upon the entertainment of others. This socioeconomic attitude influences many pa-

tients with disabilities and affects their care and management.

When an insecure personality learns he may be compensated for illness and injury, regardless of his diagnostic label, a syndrome often emerges which we have labeled "Active Dependency." In this syndrome, which appears in its medical form with many compensation cases and disability applicants, the patient begins actively, although not necessarily consciously, to try to retire. He begins to put forth effort to remain "disabled" and dependent, and thus eligible for a pension or other continued compensation.<sup>1-3</sup>

The effect of compensation upon the patient is further complicated by certain attitudes towards disability. Disabled persons frequently find difficulty in obtaining employment. Insurance companies, because some of these patients present a high risk for further illness, are reluctant to provide them with on-the-job coverage, even with a waiver. Furthermore, most of the nation's compensation systems, whether for the elderly, disabled or indigent, reduce or eliminate benefits once the patient begins to be gainfully employed. Thus, in addition to having his emotional and psychophysiological symptoms automatically reinforced by a compensation system that in effect rewards retirement, the disabled patient finds himself in a socioeconomic system which effectively penalizes his becoming well. It is not surprising under such circumstances to find that the disabled patient with basic dependency problems is often difficult to rehabilitate.

The patient who has become emotionally traumatized by a disabling traumatic experience may be realistically more insecure and dependent than he was before the injury. His emotions have

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been aroused to pathologic proportions and are now hypersensitive.

We are beginning to wonder whether many emotionally dependent disabled patients, as long as the threat of losing their disability pension is held over them, can ever return to full normal lives with work, home and recreational satisfactions. We suspect that, like diabetics, hypertensives and other psychosomatic patients, neurotics and psychotics may need continuing reliable props, such as therapists and pensions, held in reserve for them to depend on when necessary.<sup>4</sup>

Although we suspect that the Active Dependency syndrome is a function in part of our current attitudes and socioeconomic treatment of disability, several types of dependent persons are specially affected. First is the patient with strong passive-dependent wishes who fears independence and competition. Disability payments enable him to remain in a dependent position with some of his needs met as long as he remains "sick."

Being sick or disabled enables another dependent type of personality to gratify his desire to be admired as a hero. He says to himself, "I have sacrificed myself and in doing so I have become injured or sick. Now I deserve the right to be treated differently from others." From now on his disability is something to be cherished and valued and not to be lost. No wonder he is reluctant to consider the possibility of getting well.

A third type is the rebellious angry patient. When sick or injured he uses his disability as a way of conveying hostility towards authority, demanding repayment in a very angry way. His hostility towards authority, already present before he became disabled, will not permit him to try to

get well. He sees his therapist as part of the system that let him down and permitted him to get sick.

From time to time the illness of actively dependent disabled patients has to flare up in order for them to maintain or increase their compensation. Because they realize the uselessness and emptiness of their lives, they usually have very low self-esteem and are chronically depressed. In some, depression increases until they commit suicide.

Hirschfeld and Behan have proposed a model which can be used to explain the development of the Active Dependency process. In it an unrewarded, unacceptable disability is replaced by a compensated, acceptable one.<sup>5-8</sup> Susceptible persons (Fig. 1) are those with personality difficulties and a troubled life situation. This combination of personal and social problems impairs their work performance, personal lives and social position with resulting dissatisfaction and conflict—unacceptable disability.

Such persons, in a situation where the opportunity to appeal for special consideration and compensation is available, call for help. They develop hypochondriacal symptoms and behavior, appear regularly on sick call and arrive late at work. When at work, they often perform in such a risky, accident-prone manner that they appear actually to invite the traumatic event. After becoming injured or ill, they enter a posttraumatic period with an acceptable disability which now brings them the compensation they sought. However, even after their active effort to become economically dependent has succeeded, they are still not happy and satisfied. Even those whose values permit them a life style which is primarily

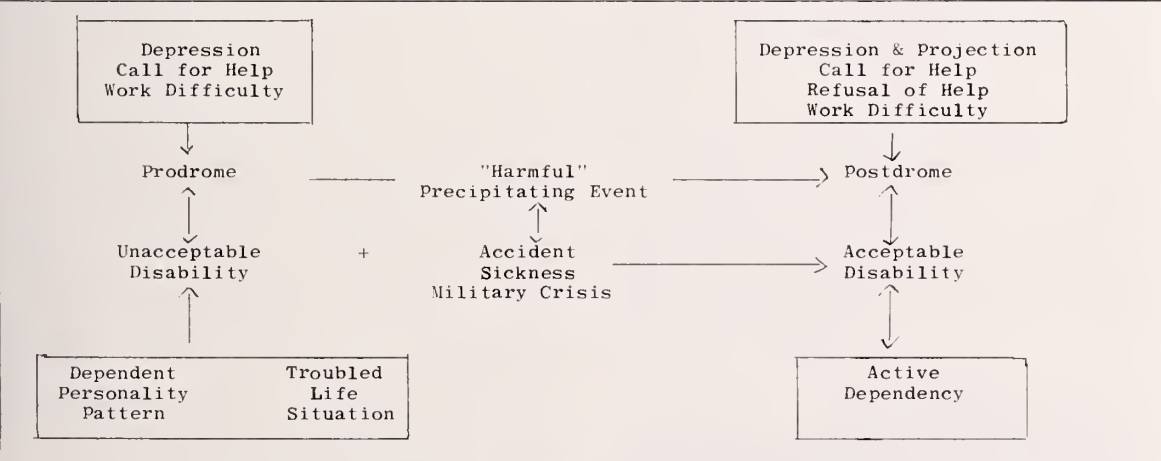


Fig. 1.—Model for the Development of Acceptable Disability and Active Dependency (Adapted from that of Hirschfeld and Behan).

consumption and pleasure oriented rarely achieve satisfaction. They require also the tolerance of their friends and family for their immature demands and expectations, and sufficient financial support to sustain the level of consumption to which they aspire. Like wealthy neurotics who have inherited money and do not work, most of these patients remain distressed and sometimes paranoid. They continue to call for help.

The following case history illustrates the problems of Active Dependency.

### Case History

The suicidal patient previously mentioned was a well-built, physically attractive, dark-haired, suntanned man. He reported that he had been functioning reasonably well up to approximately three weeks prior to admission. At that time he broke up with his girl and began to get progressively more depressed. Neck pains developed and he found himself in repeated conflicts with those around him. He got into a fight with a superior "whom I never should have hit" and stated that he was afraid he would "explode."

The patient grew up in a middle class home, the youngest of three brothers and sisters with whom he claims never to have been close. All are ten or more years older than he. His father separated from his mother before he was born. Since the mother's occupation absented her from home repeatedly, the children were raised by a grandmother with whom he claims to have had a good relationship. All of his brothers and brothers-in-law are now successful industrial executives. He claims he has had nothing to do with his family for nearly ten years.

In school he was an average student. He liked sports, particularly football, and associated with a rough crowd of fellow athletes. As a teenager he received a knife wound in the chest during an intergang rumble. He enjoyed an active social life which included a significant amount of dating. Through grade school and high school the patient held a number of small jobs.

His disability occurred when a truck in which he as a passenger was in an accident and he suffered a neck injury. His neck required fusions. He has been told that he will need repeated fusions, and he has been given a disability pension.

Subsequently, the patient attended college for two years and won a contest for an industrial design. The contest's sponsor offered him a job, he accepted and dropped out of college. This opportunity fell through when an employment physical discovered his old injury and the company's insurance carrier would not provide coverage for him. Disillusioned, he did not return to college.

In 1963 he attempted suicide after breaking up with a girl. Following a party he was drinking heavily in his room with his gun pointed at his head and his finger on the trigger. His brother-in-law knocked his arm down. The gun went off, the bullet penetrating his left arm. In a daze, wearing only pajama trousers, he walked through the parlor where his family was partying and out of the house. The police eventually found him wandering about an adjoining field. He was committed to a mental institution and vividly remembers repeated courses of shock therapy.

During two years in the hospital, he states that his family never visited him. He obtained legal help to win his freedom and regain his rights.

The patient presently works on charter fishing and tour boats without pay, but obtains \$250 a month expense money and a \$200 a month ocean-front motel apartment as fringe benefits, as well as a \$450 a month disability pension and \$120 a month social security disability pay-

ments. When not at sea he works around the motel grounds and swimming pool, loafs about with the guests and enjoys fishing and scuba diving.

Nevertheless, he became severely depressed and sought hospitalization voluntarily, stating that he could not identify anything which gave permanent meaning to his life.

This patient illustrates most of the principles discussed. Certainly his background was morbid. His treatment by an employer and insurance company destroyed his growing incentive for creative work, education, and for training his considerable artistic talents. Although disability payments, social security and expense allowances provide him with a very comfortable income, he still suffers from periodic depressions and exacerbations of symptoms. Efforts to rehabilitate him at this late date have so far been unsuccessful.

A program of care for the actively dependent must consider the four main components of dependency.<sup>9</sup> These are social, emotional, financial and psychomedical.

Social dependency is especially prevalent in minority groups and affects the whole family. They need help with purposive-oriented performance.

Emotional dependency—neurotic behavior—affects special members of the family rather than the total group. It is not specifically related to socioeconomic status.

Financial dependency is a cultural component. Veterans, welfare and social security beneficiaries and the like, 8 million people in all, are affected. Financial dependency is associated frequently with depression, related to problems of self-esteem.

Psychomedical dependency is a characteristic of the physically handicapped. These people respond by assuming a childlike state.

Intervention must focus on the specific type of dependency involved. Naturally, patients often show a combination of two or more of these specific types of dependency. In managing the social component, social workers are usually the primary therapists. Their special approach is to find rewards for attempts at independent personal and group self-development. Emotional dependency is overcome by traditional psychotherapy. Financial dependency is met best by creating and finding jobs and training the dependent persons to fill them. Psychomedical dependency is a problem for occupational, recreational and physical therapists.

To be truly effective a program of therapy and rehabilitation, therefore, requires a team effort of therapists—physicians, psychologists, psychiatrists, social workers, vocational rehabilitation



workers, O.T.'s, P.T.'s and R.T.'s in cooperation with persons in the community who affect the patient's life—family, and social, educational and employment agencies. Essential components are crisis intervention in the acute phase, minimal hospitalization, and continuing outpatient follow-up for the chronic problem. The goal of therapy involves learning to build self-esteem through constructive activity, helpfulness to others, and the development of self-control. To develop this maturity requires effort and time, and the motivation to be independent and self-reliant. Once they have become financially and emotionally secure by independent effort, patients may voluntarily give up their economic dependency.

Appropriate intervention immediately at the time the problem arises is essential. Hospitalization should only be for the treatment of the acute phase of illness, the purpose being to return the patient to the community, where he can become self-respecting, self-supporting and happy.

In many settings patients openly state that they want to be in the hospital a given number of days in order to get their disability pensions increased or maintained at a certain level. There they often learn from other sophisticated patients and other sources how to manipulate their claims.

After discharge from the hospital it is very important to continue outpatient care. Here, psychiatrists, health related professionals, and aides maintain close communication and coordination with community resources in vocational rehabilitation, education and training, sheltered workshops, employment agencies, welfare, family planning, and other community organizations. Follow-up is structured not only to help the patient and prevent possible relapses, but also to help the family in their understanding of and dealings with residual symptoms.

### Fostering Dependency

The actively dependent person does not live in a vacuum. Coupled to his dependency needs, often symbiotically, are the succoring needs of professional staff. Some staff members are deeply affected by the helpless, dependent posture of the patient. They feel compelled to "do for" him instead of acting as enablers. This smothering perpetuates his dependency. Delegation of power, authority, or autonomy to the patient is viewed by them as either rejection of the patient or as a sign of staff impotence in the treatment process.

There are, of course, other "do-gooders" and

agencies who see that the compensee's rights are maintained, protected or implemented. Their concern may be simply one of protecting their own self-interest since many people, attorneys and other professionals as well as laymen, make their living representing compensees. This suits the wishes of the actively dependent perfectly. In Young's words, "these people become predatory professional cripples and the game they stalk and feed upon is the do-gooder."<sup>10</sup>

### Economic and Social Considerations

The problem of active dependency may become still more complicated when Automated Multiphasic Health Testing and Service Centers become widespread and produce vastly greater amounts of data about patients' health and disability. Each will routinely uncover previously unrecognized heart, lung, visual and hearing defects, for example. Many unsuspected abnormalities will be potentially compensable. What can be done to manage the possible deluge of claims from the actively dependent and their attorneys once this floodgate is opened?

Russia and Scandinavian countries, which provide continuing minimum security to patients and their families, claim good therapeutic results with this type of problem.<sup>11</sup> We wonder about a number of questions. Should patients continue to receive disability compensation, at least in part, even after they return to full-time work? What will be the outcome on the Active Dependency syndrome of revamping our welfare, social security, disability, and compensation systems in line with President Nixon's Family Assistance Plan? Will a guaranteed minimum income for each family and national health insurance help produce a valuable by-product—improved therapeutic responsiveness and rehabilitation potential with dependent types of patients? Or will they merely encourage insecure personalities to stop striving to succeed, and to retire into active medical dependency with a guaranteed income crutch? In any event, changed attitudes on the part of society towards disability and idleness, especially by government, employers and insurers, is needed to provide an improved therapeutic climate in which the health professions can be more successful in rehabilitating disability patients.

References are available from the authors upon request.

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*Editor's Note: To entice you to Miami Beach next month for the 99th Annual Meeting of the Florida Medical Association, we solicited two articles for food lovers from experts in the area. To make your stay more pleasant at the meetings, reprints of these articles will be available at the registration desk in the Americana. Dr. Richard Fleming's article will appear in the May issue.*

## Restaurants of the Gold Coast

CHARLES A. MONNIN JR., M.D.

There is more to a convention than meetings, as we know. Now, let's discuss the wining and dining. Here is a list of a few of the restaurants that many of my colleagues and I have found most enjoyable.

Some restaurants are large, some are small but we have tried them all. A few we did not mention for various reasons. (Would you believe *some* are closed!).

Those with a star denote their excellence BUT CAN BE EXPENSIVE! But do not be afraid to test their excellence as it is well worth it.

En Vino Veritas

Start in the area around the Americana Hotel-Bal Harbour area, as this is close to the convention area.

**\*Fontainebleau—Club Gigi.** The Host Manager is Andre Pascal. A most elegant atmosphere for wining, dining and dancing.  
4441 Collins Avenue  
Miami Beach  
Phone: 538-8811

**Post and Paddock**—restaurant and lounge. Very popular locally and preferred by visitors; intimate and sophisticated; horsy decor. Cuisine for the epicure. Open for lunch and dinner.  
9650 East Bay Harbor Drive  
Bay Harbor Island  
Phone: 866-8706

**\*Cafe Chauveron of Florida, Inc.** New restaurant in the Bay Harbor area. French cuisine and extensive wine cellar. Outdoor terrace for cocktails adjacent to dock accommodating yachts. Reservations are a must.  
9561 East Bay Harbor Drive  
Bay Harbor Island  
Phone: 866-8779

**Golden Greek Restaurant**—Among the few restaurants with Greek cuisine.  
12500 Biscayne Boulevard  
Miami Beach  
Phone: 893-1177

**\*Bernard's Carriage House Restaurant.** Mr. Bernard and Executive Chef, Heinz Warich offer a varied continental menu. Reservations are a must. Open daily 11 a.m. for lunch; 6:30 p.m. for dinner, except Monday.  
54th and Collins Avenue  
Miami Beach  
Phone: 864-4804

**Sneaky Pete.** For food and fun (continuous entertainment) nightly from 5 p.m. to 5 a.m. Easy to find—just opposite Gulfstream Park.  
1010 South Federal Highway (U.S. 1)  
Hallandale  
Phone: 944-7197

**Nick and Arthur's.** For atmosphere and good food, and a reservation of course, try one of their delicious steaks.  
1601 North 79th Street Causeway  
North Bay Village  
Phone: 866-9759

**The Cattleman.** Known as the adult Western restaurant. Located where Broad Causeway meets Biscayne Boulevard at 124th Street. Known for its steaks.

1800 North East 124th Street  
North Miami Beach  
Phone: 891-1600

**Port of Call.** A new seafood restaurant known for its fresh seafood. Serves wines and spirits.

14411 Biscayne Boulevard  
North Miami Beach  
Phone: 945-2567

**Continental Restaurant** (Also listed as De Continental)

1045 - 95th Street  
Bal Harbour - Miami Beach  
Phone: 865-8224

**The Forge Restaurant and Lounge.** Specializing in steaks and prime rib. Dinner and supper. Open 6 p.m. to 3 a.m.

423 Arthur Godfrey Road  
Miami Beach  
Phone: 538-8533

**Joe's Stone Crab Restaurant.** Noted for stone crabs but also serves steaks and chops.

227 Biscayne Street  
Miami Beach  
Phone: 673-0365

#### Miami

**Prince Hamlet.** Famous for Danish cuisine. Open 5 p.m.-10 p.m. Closed Monday.

8301 Biscayne Boulevard  
Miami  
Phone: 757-7177

**Casa Santino.** Italian restaurant with seven dining rooms. Most famous for dining in its wine cellar.

10999 Biscayne Boulevard  
Miami  
Phone: 754-2431

**Raimondo's** is another exceptional Italian dining room where food is cooked to order (do not hurry). Famous for its classical Italian recipes. Raimondo, chef Maitre d' Rotisseur and Maitre d' Luigi.

201 N. W. 79th Street  
Miami  
Phone: 759-9403

**Valenti's** Italian cuisine is well known to all who have passed through the thresholds of Jackson Memorial Hospital.

Miami  
Phone: 379-7661

Cuban restaurants noted for their colorful floor shows and excellent Latin cuisine.

#### Les Violins

1751 Biscayne Boulevard  
Miami  
Phone: 371-8668

#### Flamenco Supper Club

991 N. E. 79th Street  
Miami  
Phone: 751-8631

#### Miami Springs Villas

**Miami Springs Villas.** Take your choice of any of the 18 dining rooms. Among the best known are the following four:

**\*The Original Japanese Steak House.** Chopsticks if your talent is there, or instructions. Prepared in front of you by the Japanese who know how.

500 Deer Run  
Miami Springs  
Phone: 871-6000

**\*King Arthur Court.** Go back in history with his knights of the roundtable (each table has the name of a knight). Add to the beautiful environment a small waterfall plus strolling violins.

500 Deer Run  
Miami Springs  
Phone: 871-6000

**My Apartment.** Small dining area where you cook the steak of your choice at your table.  
500 Deer Run  
Miami Springs  
Phone: 871-6000

If you would like to visit the private Carriage Club, ask any of the many doctors who are members or some of the personnel and you can eat, drink and dance.  
500 Deer Run  
Miami Springs  
Phone: 871-6000

#### Coral Gables

**Chez Vendome of the David Williams Hotel.** The chef is Eric Jorganson.  
700 Biltmore Way  
Coral Gables  
Phone: 443-4646

#### Fort Lauderdale-Hollywood Area

**\*Diplomat—Celebrity Room.** French food. The Maitre d', James A. Morrison, specializes in Veal Oscar and Bouillaisse Marseillaise.  
Hollywood  
Phone: 923-8111

**\*La Normandie Restaurant** (Headquarters of Les Ami du Vin). Finest French Norman restaurant. Owners: Charles and Nora Fredy.  
129 North Federal Highway, U.S. 1.  
Dania, Florida  
Phone: 927-1889

**\*Dome of the Four Seasons.** Maitre d' Pierre. Wine cellar insulated with 18" of cork on all four sides, top and bottom.  
North Fort Lauderdale  
Phone: 525-3303

**Venetian Room** on top of the Sheraton Hotel. Excellent in both food and atmosphere.  
Fort Lauderdale  
Phone: 522-7461

**Moonraker** located on an inland waterway and is a superb steak house with an unusual atmosphere and *excellent* wines. Owner, Warren E. Foster.  
3001 East Oakland Park Boulevard  
Fort Lauderdale  
Phone: 563-1211

**The Down Under** across from the Moonraker is an interesting restaurant. Again, you are on the waterfront.  
Fort Lauderdale  
Phone: 564-6984

**Cafe de Paris** is a small French restaurant in Fort Lauderdale.  
715-A East Las Olas Boulevard  
Fort Lauderdale  
Phone: 523-2900

**Cafe de Beaujolais** in Fort Lauderdale. A small French restaurant.  
34 N.E. 9th Street  
Phone: 566-1416

**Mai-Kai.** Cantonese cuisine. Famous for rum drinks and floor show. Open daily 5 p.m. to 4 a.m.  
3599 North Federal Highway  
Oakland Park  
Phone: 365-6777

**Red Coach Grill** has several locations for you to enjoy the Maine lobster or steak plus their Thursday night specialties. Dinner only.  
1200 North Federal Highway  
Fort Lauderdale  
Phone: 564-0432

1455 Biscayne Boulevard  
Miami  
Phone: 379-4008  
  
18050 Collins Avenue  
Miami Beach  
Phone: 949-5466

**South Pacific Polynesian Restaurant.** Cantonese cuisine. Nightly entertainment. Just a few minutes away.  
711 North Federal Highway  
Hallandale  
Miami phone: 949-6457

ABOUT THE AUTHOR: Apart from being the Bailli of Florida and Greater Miami, Confrerie de la Chaine des Rotisseurs, he is also a member of the Physicians Wine Appreciation Society, etc. Last year he was a judge of culinary arts in Budapest, Hungary. He is also a Compagnon de Bordeaux and a member of Les Ami du Vin.

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Reprints of this list will be available at the FMA Annual Meeting, May 9-13, 1973, Registration Desk, Americana Hotel.



# The Seed

DAVID J. LEHMAN JR., M.D.

**Abstract:** "The Seed" programs located in Broward and Dade Counties are nonresidential, day care therapeutic communities. They utilize innovative techniques developed by Art and Shelley Barker which have helped several thousand children in south Florida with drug problems. Eleven factors are presented that may help to explain the present drug abuse epidemic. The author suggests certain remedial measures that might halt the epidemic's continued escalation and expresses the opinion that "The Seed" program techniques might reduce the recidivism rate seen in some other drug programs.

"The Seed" was founded by Art and Shelley Barker in Fort Lauderdale in 1970. Initially there were 80 children; now more than 2,000 young people are enrolled or have been through the program. It was recently moved to a 23 acre location on State Road 84 in Davie and a \$1 million building program has begun. A branch has been opened in Dade County and 500 children are in this program. "The Seed" has received LEAA and NIMH grants and is seeking additional grant monies.

Children, affectionately labeled "seedlings," enter the program by parental request on a voluntary basis and by direct referral from a judge, parole and probation officer; principal, dean or guidance counselor of a school with parental consent, and doctors, psychiatrists, psychologists, lawyers and clergymen. Young adults may enter if they are 21 years old.

## Program Explained

R. Urbanik of North Carolina explains "The Seed" program.<sup>1</sup>

Counselors or staff members are rehabilitated drug offenders. After having gone through the program they are judged to have the necessary skills and motivation. These basically consist of the ability to empathize with others, the strong desires and dedication to help others and themselves, and finally the ability to become skillful group leaders. The group sessions themselves may be loosely categorized . . . What happens is that formal and informal group pressures are brought to bear upon the individual members by other members and the leader. . . . The staff members are extremely skilled in handling the various forces and pressures that are operating. They are also extremely adept at reading the character of each member and then skillfully applying or halting the pressures. Having once been offenders ("druggies") themselves they are able to pierce the protective shells of self-deceit that each druggie throws about himself. They refuse to fall into the verbal and cognitive traps that druggies set up. The leader sees the games the other is playing, he refuses to play the games, and then he points out to the individual how these games have led that individual to his present state of affairs. The atmosphere in which this guided interaction takes place is basically made of affection, empathy and love. . . . In social power terms, the leader has been endowed with a referent power by the other members of the group. While at no time will he deny any group member, he does, however, skillfully manage its application. He uses it to maintain motivation on the part of members by reassuring those members who may have just received the brunt of a group session.

A seedling attends two weeks of sessions from 10:00 a.m. to 10:00 p.m. and lives with a foster parent from 10:00 p.m. until 10:00 a.m. This period can be extended if necessary. Then he is placed on a "3-months schedule," permitted to return home, to school or work. During this period he returns for group sessions three nights a week including one open session night on Monday or Friday, and one day over the weekend. The program is completely drug-free and the seedlings maintain security.

During the day there are continual group discussions ("raps") and in the evening a general session attended by every seedling. On Monday and

Dr. Lehman is chairman of the Drug Abuse Committee of the Broward County Medical Association and a member of the Committee on Drug Abuse of the Florida Medical Association.

Friday nights an open session is held beginning at 7:30 p.m. attended by all seedlings, their parents and other interested persons. Parents talk with their children over a microphone, and many conversations are highly emotional. This portion is meaningful and encourages the involvement of all family members. Involvement also includes the provision of foster homes, daily transportation, and assistance in preparing meals.

The Seed is a non-profit, tax-exempt organization and depends on donations from the community, as well as income from government grants, for its operating expenses. The average cost per client during treatment amounts to \$250.

### Drug Abuse Epidemic

The abuse of drugs especially among teenagers is at epidemic proportions.<sup>2,3</sup> Many children are entering the scene as early as the third grade with delirants and pills. Parents should be warned of the potentially harmful effects of permissiveness, overindulgence and lack of discipline within the family setting. It is regrettable that they know less than their children about drugs, a situation that might be rectified by study and communication with the children in the home.

At least 11 factors may account for the drug abuse epidemic.<sup>4</sup>

1. Community leaders and parents often have chosen to ignore or have over-reacted when a drug problem is found. The result is a tremendous burden on law enforcement agencies. Perhaps threats of incarceration encourage some children to use drugs.

2. "Prevention programs" are virtually nonexistent.<sup>5</sup> The National Coordinating Council on Drug Education has stated that "it is better to show nothing to the students than show existing drug abuse films."<sup>6</sup> Didactic lectures are presented by inadequately trained personnel unable to cope with the questions. Dr. S. H. Schuman has highlighted the deficiencies in a JAMA article.<sup>7</sup>

3. Some elected and/or appointed officials fail to realize that experimentation or peer pressure cannot be legislated against; that incarceration without rehabilitation is at best a poor stopgap and encourages recidivism. It is unrealistic to have the same legal penalties for a child experimenting with dangerous drugs and a pusher.

4. News media generally have emphasized the criminal aspects of the drug scene. Raids and arrests are stressed; young people engaged in meaningful community activities rarely are head-

lined or appear on television. A welcome change was the TV film, "The Seed of Hope," which realistically portrayed "The Seed" program.

5. Children usually begin using drugs in school or restaurants or stores near schools. There is little a principal can do except admit the presence of drugs and endeavor to develop new and innovative activities for students during and after school. In 1971 the Committee on Drug Abuse of the Florida Medical Association presented to the Board of Governors specific guidelines to encourage communication between a youthful drug user and a teacher, guidance counselor or dean. These guidelines have been distributed to all school systems by Shelley S. Boone, Division of Elementary and Secondary Education, Bureau of Curriculum and Instruction, Florida Department of Education. An important point is that it is not against federal or state statute for a teacher, guidance counselor, dean or principal to discuss a drug problem with a student. If the problem is serious, a meaningful referral can be made to a physician or local drug program.

6. Use of methadone either in a detoxification or maintenance program has been the main thrust of the United States government to combat narcotic addiction. Many children now are "methadone addicts;" others sell methadone for heroin. I believe that giving methadone to children is "bad medicine," particularly since a superior alternative is available in "The Seed" program. Young people using heroin admitted into "The Seed" program have virtually no withdrawal symptoms.

7. A change in behavior and attitude is the most common and easily recognizable sign in a child beginning to use drugs. This refutes the statement that drug abuse is a symptom of some underlying emotional or mental problem. I believe the reverse is true—it really has to be with the majority of high school students using drugs today. Most come from good homes and have no special emotional problems, no more than anyone else as they grow up.

8. Multiple drug agencies are found in most large metropolitan areas. Their effectiveness may be diminished by intense competition for money, prestige and power. All agencies should be under the broad umbrella of the local county medical society. Probably the most effective, comprehensive community drug program in America is the CODAC program under the Maricopa County Medical Society in Phoenix, Ariz.

9. Improved communication is needed be-



tween community drug planning agencies and federal and state agencies responsible for distributing grant monies. A possible solution would be to increase the number of federal and state representatives at the local level to assist with the writing of grants and the evaluation of agencies.

10. Pharmaceutical manufacturers have been reluctant to accept a meaningful role in the reduction of drug abuse in America. Overmanufacturing of amphetamines and barbiturates continues far above actual medical needs. Security measures have been inadequate to reduce hijacking, pilfering and stock substitutions within the manufacturing plants, and failure in some cases to institute newer methods to label packages of drugs so that hijackers will not know the contents. The AMA has recommended that physicians drastically reduce the prescribing of amphetamines. Perhaps some defects might be corrected by new legislation.

11. Dr. Herbert Berger stated that a survey

of 510 young addicts revealed an absolute hatred of school.<sup>5</sup> They felt school to be a jail into which they had been unjustly committed. He further stated that "education is an opportunity. It cannot be both a compulsive punishment and a privilege simultaneously. Therefore, it would be advisable that the child who displays no interest in school be permitted to discontinue his formal education."

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4. Lehman, D. J.: Psychology 310, Ft. Lauderdale University 1971-72.
5. Berger, H.: Here's How We Can Prevent Drug Addiction, Medical Times, March 1972.
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► Dr. Lehman, 2740 Hollywood Boulevard, Hollywood 33020.



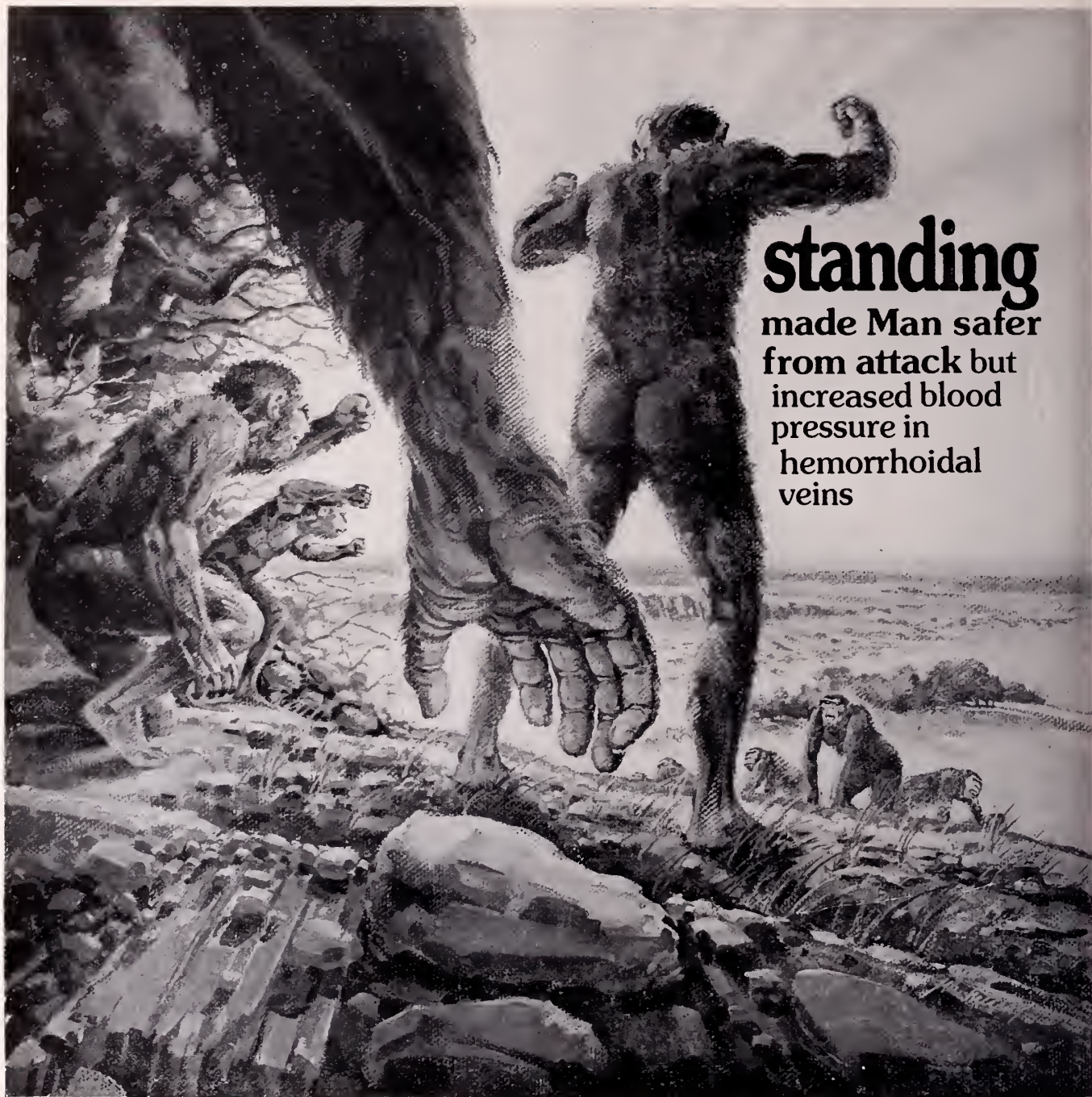
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Prolonged or excessive use of Anusol-HC might produce systemic corticosteroid effects. Symptomatic relief should not delay definitive diagnosis or treatment.

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**two tubes...two weeks**

\*

**Indication:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

"Probably" effective: For the treatment of vulvovaginal candidiasis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** None known. **Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued. **Dosage:** One applicatorful intravaginally twice daily for a period of 14 days. Course of therapy may be repeated if necessary.

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## Editorials

### The Chosen People

The Old Testament notwithstanding, it has occurred to me that we, the medical profession, are the Chosen People. We have been singled out as a unique segment of the general population by the government. The awareness of this uniqueness begins on graduation from medical school and the attainment of the long sought after M.D. degree. We then become subject to the "doctor draft." In peacetime, the medical profession is the only one chosen to have its own draft.

As the government becomes more and more involved in health care, we are once again chosen for special attention. More and more restrictions, caveats, and interpositions spew forth from Washington. One need not labor this point; it is a harsh reality we all face daily.

Now, with Phase 3 in Mr. Nixon's economic program, we are once again chosen to be separated from the main stream. The "Health Industry" must abide by rules that are not universally applied. Salaries and incomes remain under government control and fee increases are restricted

to less than the current rate of inflation. The legal profession, for example, continues on its untrammelled way, while we must practice according to bureaucratic fiat.

More remarkable is the lack of hue and cry over this plainly undemocratic, if not unconstitutional, situation. Where is the A.C.L.U. when you really need it? The AMA spokesmen did protest but with no way of effectively resisting the ruling except to threaten to stuff beans up our collective noses if some change were not forthcoming. We seem to lack any leverage in combating these encroachments. It is small wonder that the attraction of Guilds, Associations, and Unions grows for the practicing physician. That is the way it is when you are a member of the Chosen People. As Abraham Lincoln quoted the man who was being tarred and feathered: "If it weren't for the honor, I would just as soon forego the whole thing."

R.T.D.

## Life Savers

Someday, manufacturers will perfect and install remarkable and failure-proof life saving devices in all new cars. At the present, based on theories that cushioning the impact of the crash protects the occupants and the driver, are new devices on the planning boards called passive restraints. Such a device is any contraption which does not have to be fastened by the rider or driver and which automatically protects him in a crash against a rigid barrier while going more than thirty miles an hour. One idea being pushed by the U. S. government agents and fought in the courts by the Big Three auto manufacturers, is the controversial *airbag*. This new attachment is an empty plastic sack folded beneath the instrument panel and also in back of the front seats which, when the vehicle receives a jar, opens a cylinder of compressed air, inflating the bag rapidly. This forms a cushion between the rider's body and the instrument panel, or the windshield of the automobile. Theoretically, the occupant survives unhurt, cuddled like an egg in a crate instead of being smashed against the front of the car or thrown through the windshield. But what happens to the glasses the driver is wearing, the cigarette he is smoking, the baby the passenger is holding or to the small child in the back seat? No one knows for sure for most tests have been done with robots.

Other passive devices are nylon blankets that spring up in front of the passenger and seats that wrap plastic arms around him as a mother enfolds her child. One alternative is an ignition interlock that won't allow the car to start until all seat belts are fastened. Seat belts and shoulder harnesses are also being made of inflatable material.

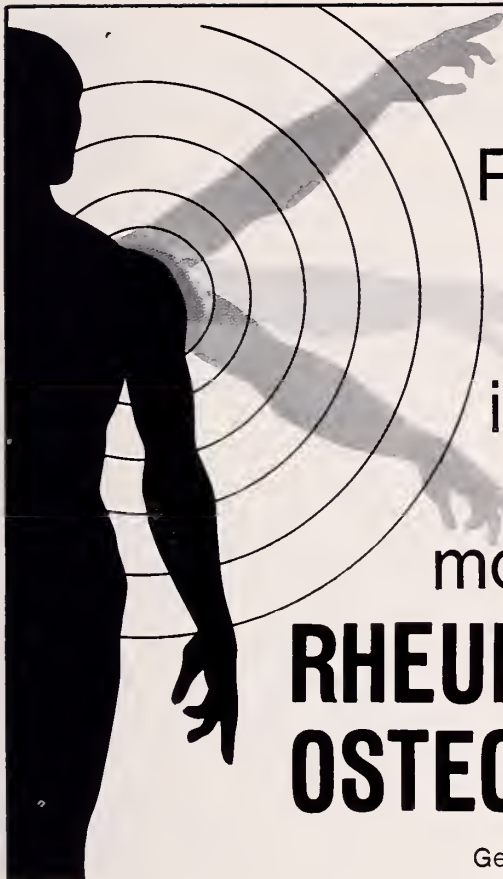
Originally, the Department of Transportation, wanting to make cars safer and believing that passive restraints would save more lives than seat

belts, ordered these safety devices be perfected and in new automobiles by 1972. Detroit said this was impossible so Washington relented. New designs are being experimented with to enable these passive restraints to work in side collisions, rear-enders and rollovers. Some protect the passenger from head to waist while another protects them only from the waist to the feet. Initially, the idea was to eliminate the need for a driver to fasten his seat belt, but tests have shown that without a seat belt, the driver or passenger will slide beneath the bag.

Not having been used in real accidents, Detroit claims there will be frequent malfunctioning of the bags for they may go off by mistake or the jar from a child's toy or a rough road may cause the bag to inflate. Loss of cylinder pressure, deterioration of the bag as it gets older and how soon after the initial inflation, if the car is hit again, will the bag be effective raise some doubts as to their true value. Some experts say that installation should be held off until there are many real life tests. Others say that lives can be saved by going ahead and installing them now and accumulating some data. Detroit estimates that the two bags would add \$200 to a new car's cost while the government believes that it could be done for \$100.

Authorities say that the best safety device yet invented is the simple shoulder harness that almost no one uses. Statistics reveal that it's value to the driver and his family is beyond belief. In case after case, people who have worn these restraints, have been seen crawling out alive from wrecks where in other similar collisions when shoulder harnesses are not worn, all were severely injured or killed. So, take a tip, buckle your seat belt as well as your shoulder harness. This is the real miracle life saver for which we have been waiting.

C.M.C.



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1. Gordon, E. E. and Haas, A.,  
Indust. Med. & Surg. 28:217, May, 1959.

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# MEETINGS

Approved by FMA  
Committee on Continuing Education

## APRIL

- 16-21 Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.
- 27-29 A Workshop on the Diagnosis and Treatment of Childhood Cancer, University of Florida, Gainesville 32601. For information: Division of Continuing Education, University of Florida, Box 758, Gainesville 32601.

## MAY

- 4- 5 The Management of the Critically Ill Patient, University of Florida, Gainesville. For information: Division of Continuing Education, University of Florida, Box 758, Gainesville 32601.
- 18 Acupuncture — Electrical Stimulation — A Critical Review With Demonstrations in Pain Control Techniques, University of Florida, Gainesville. For information: Division of Continuing Education, University of Florida, Box 758, Gainesville 32601.
- 28-30 Fourth Annual Topics in Internal Medicine, University of Florida College of Medicine, Gainesville. For information: Division of Continuing Education, Box 758, Gainesville 32601. (Dates changed from May 9-11).
- 29-31 Master Interpretation of Clinical Electrophysiology, Contemporary Hotel, Disney World, Lake Buena Vista, Florida. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

## JUNE

- 11-16 Seventh Annual Workshop in Electrocardiography, Tides Hotel and Bath Club, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

National and Regional  
Meetings Held in Florida

## MAY

- 3- 5 Association of Clinical Scientists, Hawaiian Village, Tampa. For information: F. William Sunderman Jr., M.D., University of Connecticut School of Medicine, Drawer B., Newington 06111.
- 3- 7 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. For information: Robert D. Reinecke, M.D., Albany Medical College, Albany, N. Y. 12208.
- 6-12 American Society for Microbiology, Fontainebleau Hotel, Miami Beach. For information: Mr. R. W. Sarber, 1913 I St., N.W., Washington, D. C. 20006.
- 12-14 American Association of Blue Shield Plans, Diplomat Hotel, Hollywood, Fla. For information: Jean A. Borger, 211 E. Chicago Ave., Chicago 60611.
- 21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Donald F. Richardson, One East Wacker Dr., Chicago 60601.

## JUNE

- 11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

## OCTOBER

- 21-25 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Miami Beach. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

## NOVEMBER

- 8-10 Gerontological Society, Deauville Hotel, Miami Beach. Exec. Dir.: Mr. Edwin Kas-kowitz, 1 Dupont Circle, Washington, D.C. 20036.
- 11-16 American Association of Blood Banks, Americana Hotel, Miami Beach. Central Office Manager: Miss Lois J. James, 30 North Michigan Avenue, Chicago 60602.

Next FMA Annual Meeting: May 9-13, 1973, Bal Harbour



## ORGANIZATION

### Annual Meeting Scientific Sections

The following scientific sections will be held during the 1973 annual meeting of the Florida Medical Association, May 9-13 in the Americana Hotel, Bal Harbour. Complete programs and time schedules will appear in the official annual meeting program.

#### Section on Arthritis

Thursday Afternoon, May 10th

Program Chairman: J. R. Caldwell, M.D.

(Program not available)

#### Section on Birth Defects

Thursday Evening, May 10th

(Program not available)

#### Section on Chest Medicine

Thursday Afternoon, May 10th

Program Chairman: Eugene J. Sayfie, M.D.

(Program not available)

#### Section on Internal Medicine

Friday Morning, May 11th

Program Chairmen: Chester Cassel, M.D.  
Martin E. Liebling, M.D.

"Pharmacologic Mainstays of Clinical Practice"

"Antibiotics: New Uses for Old Drugs,"  
Kenneth R. Ratzan, M.D., Assistant Professor of Medicine, University of Miami School of Medicine and Chief, Infectious Disease Section, Miami VA Hospital

"Corticosteroids in Clinical Practice,"  
Lawrence M. Fishman, M.D., Associate Professor of Medicine, University of Miami School of Medicine and Chief, Endocrinology and Metabolism Section, Miami VA Hospital

"Hypotensive Drug Therapy," Eliseo C. Perez-Stable, M.D., Professor of Medicine, University of Miami School of Medicine and Chief, Medical Service, Miami VA Hospital

Panel Discussion

#### Section on Hypertension

Thursday Afternoon, May 10th

Program Chairman: Lamar Crevasse, M.D.

(Speaker to be announced)

Ray Wallace Gifford Jr., M.D., Chairman, Department of Hypertension and Nephrology, Cleveland Clinics

Edward H. Kass, M.D., Director, Channing Laboratory, Boston, and Professor of Medicine, Harvard Medical School

Audience reaction and discussion with faculty panel

#### Section on

#### Medical Aspects of Marijuana

Friday Morning, May 11th

Program Chairman: David J. Lehman Jr., M.D.

(Program not available)

## Section on Otolaryngology

Friday Morning, May 11th

Program Chairman: John W. Stone, M.D.

"Otolaryngology in Everyday Medical Practice"

(Program not available)

## Section on Diabetes

Friday Afternoon, May 11th

Program Chairman: Eugene T. Davidson, M.D.

"Diabetes and Pregnancy," William Spelacy, M.D., Department of Obstetrics and Gynecology, University of Miami School of Medicine

"Triiodothyronine Thyrotoxicosis and Newer Aspects of Thyroid Disease," Charles S. Hollander, M.D., Chief, Division of Endocrinology, New York University School of Medicine

"What is Good Diabetic Control?" Daniel Mintz, M.D., Chairman, Department of Endocrinology, University of Miami School of Medicine

"Hypoglycemia, Fact or Fiction?" Robert Katims, M.D., Endocrinologist

## Section on Emergency Medicine

Friday Afternoon, May 11th

Program Chairman: John L. Buckingham, M.D.

"Advances in Emergency, Medical and Surgical Care"

(Program not available)

## Section on Family Practice/Otolaryngology

Friday Afternoon, May 11th

Program Chairmen: John W. Stone, M.D.

Bernard Kimmel, M.D.

"Recognition of Common Otolgic Diseases," Richard A. Buckingham, M.D., Department of Otorhinolaryngology, University of Illinois Medical School

Round Table Discussion and Questions

Coffee Break

"Evaluation of Masses in the Neck," Burton Soboroff, M.D., Department of Otorhinolaryngology, University of Illinois Medical School

Round Table Discussion and Questions

## Section on Medical Education

Friday Afternoon, May 11th

Program Chairmen: Robert E. Windom, M.D.

Henry R. Cooper, M.D.

(Program not available)

## Section on Orthopedics/Pediatrics

Friday Afternoon, May 11th

Program Chairmen: George A. Richard, M.D.

Ronald J. Mann, M.D.

Moderator: Louis Brady, M.D. (Session 1)

"Osteomyelitis and Pyogenic Arthritis: Medical Approach," Stanford Shulman, M.D., Instructor of Pediatrics, University of Florida College of Medicine

"Osteomyelitis and Pyogenic Arthritis: Surgical Approach," Howard Hogshead, M.D., Associate Professor of Orthopedics and Pediatrics, University of Florida College of Medicine

Discussion

"Hemophilia and Joint Disease," Kjell Koch, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine

Discussion

"The Battered Child Syndrome," Donald Altman, M.D., Chief, Department of Radiology, Variety Childrens Hospital, Miami

Discussion

Coffee Break

Moderator: Robert J. Grayson, M.D. (Session 2)

"The Management of the Spastic Child," E. Burke Evans, M.D., Professor and Chairman of Orthopedics, University of Texas College of Medicine, Galveston

Discussion

"Short Limbed Dwarfism," Jaime Frias, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine

Discussion

"Vitamin D Resistant Rickets," John Malone, M.D., Assistant Professor of Pediatrics, University of South Florida School of Medicine

Discussion

"Why a Team Physician?" Ronald J. Mann, M.D., Assistant Professor of Orthopedics and Rehabilitative Surgery, University of Miami School of Medicine

Discussion

## Section on Pathology

Friday Afternoon, May 11th

Program Chairman: Daniel Seckinger, M.D.

(Program not available)



## Section on Preventive Medicine

Friday Afternoon, May 11th

Program Chairman: James J. Hutson, M.D.

(Program not available)

## Section on Psychiatry

Friday Afternoon, May 11th

Program Chairman: Samuel I. Greenberg, M.D.

"New Developments in Psychiatric Treatment"

"Useful Drugs," William L. Gustafson, M.D., Clinical Professor of Psychiatry, University of Miami School of Medicine and Martin Rosenthal, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine

"Behavior Modification: Theoretical Basis, Indications and Results," Charles Kram, Ph.D., Assistant Professor of Psychiatry, University of Miami School of Medicine and Chief Psychologist, Jackson Memorial Hospital, Miami

"Family Therapy: Goals and Limitations," Edward J. Carroll, M.D., Clinical Professor of Psychiatry, University of Miami School of Medicine and Samuel I. Greenberg, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine

"Psychotherapy: Current Practice and Future Developments," Alberto de la Torre, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine and Elaine F. Needell, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine

## Section on Radiology

Friday Afternoon, May 11th

Program Chairman: Carl E. Fabian, M.D.

(Program not available)

## Section on Dermatology

Saturday Morning, May 12th

Program Chairman: Gerald Weinstein, M.D.

(Program not available)

## Section on General Surgery

Saturday Morning, May 12th

Program Chairman: David S. Hubbell, M.D.

(Program not available)

## Section on Internal Medicine

Saturday Morning, May 12th

Program Chairmen: Chester Cassel, M.D.

Martin E. Liebling, M.D.

"Practical Principles of Immunization," Robert H. Waldman, M.D., Assistant Professor in Immunology and Medical Microbiology, University of Florida College of Medicine

Detection and Treatment of Gonococcal Infections," Stuart M. Polly, M.D., Clinical Fellow, Department of Infectious Diseases, University of Florida College of Medicine  
"Adverse Drug Reactions Leading to Hospitalization," George J. Caranasos, M.D., Assistant Professor of Medicine, University of Florida College of Medicine

Question and Answer Period

## Section on Neurology

Saturday Morning, May 12th

(Program not available)

## Section on Neurosurgery

Saturday Morning, May 12th

Program Chairman: Donald Sheffel, M.D.

(Program not available)

## Section on Obstetrics and Gynecology

Saturday Morning, May 12th

Program Chairmen: C. H. Gilliland, M.D.

Henry L. Wright, M.D.

(Program not available)

## Section on Ophthalmology

Saturday Morning, May 12th

Program Chairman: Alfred G. Smith, M.D.

(Program not available)

## Section on Orthopedic Surgery

Saturday Morning, May 12th

Program Chairman: Walter C. Jones III, M.D.

(Program not available)

## Section on Pediatrics

Saturday Morning, May 12th

Program Chairman: George A. Richard, M.D.

Moderator: Henry Redd, M.D. (Session 1)

"Urinary Tract Infections: Diagnosis, Treatment and Followup," Robert Fennell III, M.D., Fellow in Pediatric Nephrology, University of Florida College of Medicine Discussion

"Complications in the Treatment of Meningitis," James Hallock, M.D., Assistant Professor of Pediatrics, University of South Florida School of Medicine Discussion

"Metabolic Emergencies in the Newborn," Owen M. Rennert, M.D., Professor of Pediatrics and Chief, Institutional Division of Genetics, Endocrinology and Metabolism, University of Florida College of Medicine Discussion

"Diagnosis and Management of Chronic Diarrhea in Early Childhood," Douglas Sandberg, M.D., Associate Professor of Pediatrics and Co-Director of Clinical Research Center, University of Miami School of Medicine Discussion

Coffee Break

Moderator: Michael L. Steiner, M.D. (Session 2)

"The Pediatrician's Role in the Early Identification and Management of the Infant With Congenital Heart Disease," Henry Gelband, M.D., Assistant Professor of Pediatrics and Pharmacology, University of Miami School of Medicine Discussion

"Brain Tumors in Childhood," Stuart B. Brown, M.D., Associate Professor of Neurology and Pediatrics, University of Miami School of Medicine Discussion

"Experience With Drug Administration in Children," Charles Weiss, M.D., Associate Professor and Chief of Pediatric Pharmacology, University of Florida College of Medicine Discussion

## Section on Plastic and Reconstructive Surgery

Saturday Morning, May 12th

Program Chairman: Dorothea Weybright, M.D.

Guest Speaker: "Helpful Refinements in Aesthetic Surgical Procedures," Verner Lindgren, M.D., Portland, Oregon

(Program not available)

## Section on Colon and Rectal Surgery

Saturday Morning, May 12th

Program Chairman: Manuel L. Carbonell, M.D.

(Program not available)

## Section on Radiology

Saturday Morning, May 12th

Program Chairman: Carl E. Fabian, M.D.

(Program not available)

## Section on Voluntary Health Agencies

Saturday Morning, May 12th

Program Chairman: Robert E. Windom, M.D.

(Program not available)

## Section on Allergy

Saturday Afternoon, May 12th

Program Chairman: Albert M. Ziffer, M.D.

Guest Speaker: "Hypersensitivity Pneumonitis," John E. Salvaggio, M.D., University of Colorado Medical School, Denver

## Section on Dermatology

Saturday Afternoon, May 12th

Program Chairman: Gerald Weinstein, M.D.

(Program not available)

## Section on Health Education

Saturday Afternoon, May 12th

Program Chairman: Mrs. James J. De Vito

(Program not available)

## Section on Neurosurgery

Saturday Afternoon, May 12th

Program Chairman: Donald Sheffel, M.D.

(Program not available)

## Section on Pediatric Surgery

Saturday Afternoon, May 12th

Program Chairman: Malvin Weinberger, M.D.

(Program not available)

## Section on Thoracic and Cardiovascular Surgery

Saturday Afternoon, May 12th

Program Chairman: John P. Collins, M.D.

(Program not available)

**Must vasodilators  
and therapy for  
other diseases  
come into  
conflict?**



**not if the vasodilator is**

**VASODILAN<sup>®</sup>**  
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no treatment conflicts reported**

The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

**Possibly Effective:**

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: *Geriatrics* 25:134-148 (May) 1970.

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## Medical News

### Ob.-Gyn. Officers

Two Miami physicians have been elected to three-year terms as officers of the Florida Section of the American College of Obstetricians and Gynecologists. They are: O. William Davenport, M.D., Chairman; and Joseph A. DeCenzo, M.D., Vice Chairman.

### Clinic Directors Elect

Jose R. Lombillo, M.D. has been named president-elect of the Florida Council of Mental Health Clinic Directors, Inc. at their annual meeting. In addition, he will serve as chairman of the Council's Committee on the Florida Mental Health Institute in Tampa. He is presently director of the Collier County Mental Health Clinic located in Naples, Florida.

### New Anesthesiology Professor

Martin I. Gold, M.D., has joined the University of Miami School of Medicine as Professor of Anesthesiology with concurrent duties as Chief of Anesthesiology at the Miami Veterans Administration Hospital.

A 1954 graduate of the College of Medicine of the State University of New York, Dr. Gold is the author of more than 50 scientific papers. For the past five years he was Professor of Anesthesiology at the University of Maryland School of Medicine.

### Board of Family Practice Diplomates

Fifty-two Florida physicians were certified as Diplomates of the American Board of Family Practice as a result of the 1972 examination, according to the Winter 1973 issue of *Florida Family Physician*.

According to the magazine, the following were certified:

Drs. Charles Anderson Augustus, George Conley Bingham, Timothy Francis Harrington, and John Adam Zapp III, all of Pensacola; Efrain C. Azmitia and Arland Wayne Lafferty, both of Tampa; Harold Baumgarten, Duane L. Bork, Charles Hullett Burke, John V. Dervin, John P. DeSimone, William Bryan Lyle Jr., A. Mackenzie Manson, and Guy T. Selander, all of Jacksonville; Billy Brashers and William C. Evans Jr., both of Gainesville; and Alexander D. Brickler of Tallahassee.

Drs. Anthony Camelo of Margate; William Benedict Davis of Naples; Norman Francis Fain Jr. and William Stanley Lanford, both of Melbourne; Harvey Allen Fleisher, Joseph Andrew Hill, Victor P. Krestow, and George Theodore Venis, all of Miami; L. Marshall Goldstein of Miami Beach; James Howard Habegger of Rockledge; Anthony Wesson Holt and Edwin W. Turner, both of Homestead AFB; and Douglas Whitney Hood and William Griffen Jefferey, both of St. Petersburg.

Drs. Wayne R. Johnson of Hollywood; Bertis B. Jordan of Gulf Breeze; Bernard Kimmel of West Palm Beach; Wiley Emmett Koon of Winter Haven; John Ian MacDonald and Gary Donald Miller, both of Orlando; John F. McGarry and Thomas F. Scott, both of Sarasota; Delores Ann Morgan of Key Biscayne; Michael G. Morgan of Lehigh Acres; Robert J. Nealy of Dunedin; Benjamin Goodrich Newman of Longwood; Ernest P. Palmer of Wauchula; Charles Sumner Quimby and Robert Campbell White, both of Bradenton; I. Randall Ross of Merritt Island; William Barry Shore of Coconut Grove; W. Raleigh Thompson Jr., and Willie Glen Wyatt, both of Orange Park; Frederick J. Weigand of Deltona; and Robert Erwin Willner of North Miami Beach.

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## Selecting Blue Shield Board Members

Along about this time each year the manner in which candidates for election to the Blue Shield Board of Directors are nominated excites a great deal of interest. How did Old Joe get nominated? Why isn't my county medical society represented on the Board? Why isn't there a nuclear physicist on the Board? Why wasn't I consulted about Old Joe? And so forth, and so forth, and so forth. It is in an attempt to answer such questions and to shed a little light on the subject that this is written.

The manner of electing Blue Shield directors has been the same for the past eighteen years. It is unquestionably the most democratic, the most careful, and the most deliberate of any nominating process in which the Florida Medical Association participates. Some time each fall the Chairman of the Blue Shield Board selects a nominating committee consisting of two members from the Blue Shield Board, two from the Board of Governors of the Florida Medical Association, and one from the Florida Medical Association at large; thereafter, the nominating committee is on its own. It elects its own chairman is charged with selecting three or more nominees for each vacancy to be filled by a doctor, one for *each* vacancy for a layman, and one for the vacancy to be filled by a hospital administrator member of the Blue Cross Board. The committee is unrestricted in the manner in which it goes about accomplishing its duties; however, it must report its nominees to the FMA Board of Governors by January 1. The Board reduces the three doctor nominees for each position to two and approves or rejects the lay and Blue Cross nominees. In case it rejects any lay nominee or enough doctor nominees to leave less

than two nominees for each doctor vacancy, the nominating committee must then present more nominees. The slate approved by the Board of Governors is published and placed before the House of Delegates. *Then*, nominees are called for from the floor of the House.

So much for the technicalities, now how does it actually work? The last two years it has been my duty as Chairman of the Board to select the nominating committee. Last year the committee consisted of Dr. Tom McKell of Tampa and Dr. Joe Matthews of Orlando from the Blue Shield Board, Dr. Henry Babers of Gainesville and Dr. Merrill Wilhoit of Pensacola from the Board of Governors, and Dr. Rufus Broadway of Miami from the State at large. The following letter was sent by me to each member of the committee:

In general, a member of the Board who has served one term satisfactorily should be renominated. It takes one to two years of service for a Board member to become sufficiently knowledgeable to serve effectively. Renomination for a third term is questionable; and for a fourth term, should be avoided except in extremely unusual circumstances. This generalization does not apply to the lay members of the Board in whom long service is of particular value. It is important that Blue Shield have a constant infusion of new blood on its Board, and equally important that there be a large number of doctors knowledgeable about Blue Shield, such as former Board members, among the physicians of Florida.

There are several personal characteristics that a Board member should have: (1) He should be interested in, and willing to work as a Board member of, Blue Shield. (2) Every Board member represents *all* the doctors of Florida regardless of where he lives or what specialty he practices. He should be objective in his thinking and able to sublimate his own interest for the interest of the whole. He should have the support of all the doctors of Florida, especially those in the locality in which he lives.

Insofar as possible, as many different areas of the state and as many different specialty interests as possible should be represented on the Board. The *man* is

the most important single consideration, but other things being equal, two men from the same city should not be nominated where a man of equal promise from another area is available. The same principle applies to specialty interest.

At least three, more if you like, nominees should be made for each vacancy. This does not apply to the lay members of the Board of whom only one is nominated for each position.

Consideration of the composition of the carryover Board should be given in making your selection of the nominees for the vacancies.

Dr. McKell wrote over 150 letters to county medical society presidents and secretaries, various specialty society officers, committee chairmen of the Florida Medical Association, and others asking for nominees to the Board. After considering the voluminous correspondence which resulted, nominees were named. This year Dr. Joe Matthews of Orlando and Dr. Bud Harrison of Tallahassee from the Blue Shield Board, Dr. Burns Dobbins of Ft. Lauderdale and Dr. Dick Dever of Miami from the Board of Governors, and Dr. Henry Morton of Sarasota comprise the nominating committee, with Dr. Matthews serving as chairman. Again, the committee has sought advice from doctors throughout the state concerning nominees and has submitted its recommendations to the Board of Governors.

One wonders why after all this effort to obtain geographic and specialty representation of doctors who have received advanced approval from county medical society or specialty society officers and so forth, nominations should be accepted from the floor. I think the answer to this question lies in the fact that the House of Delegates, which represents both subscriber and participating physician, should retain complete control over the composi-

tion of the Board, and anyone who can be nominated from the floor and elected *should* be elected. Currently serving on the Board are two such members.

I don't know of any better way of selecting Blue Shield Board members than that presently used. Very few people campaign for election to the Board. Yet Board members should be carefully selected and should have the support of those whom they represent. It has been interesting to me in my eight years on the Board to observe my fellow Board members as they come on the Board and assume what are sometimes rather awesome responsibilities. Without exception, these men individually and collectively have in my opinion measured up to their responsibilities. This in itself, I think, is justification for the deliberate nominating system which we have and for faith in the collective good judgment of the House of Delegates in selecting Blue Shield Board members.

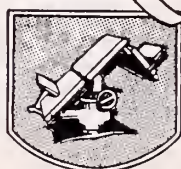
This year another selection of outstanding physicians and laymen will be presented to the House for filling of vacancies on the Board. The House will have the opportunity of selecting the new physician Board members from among those nominated by the committee and approved by the Board of Governors, or those nominated from the floor. In either event I am confident that the Blue Shield Board will continue to count among its members some of Florida's most able physicians.

ROBERT E. ZELLNER, M.D.  
ORLANDO

Dr. Zellner is Chairman of the Blue Shield Board.

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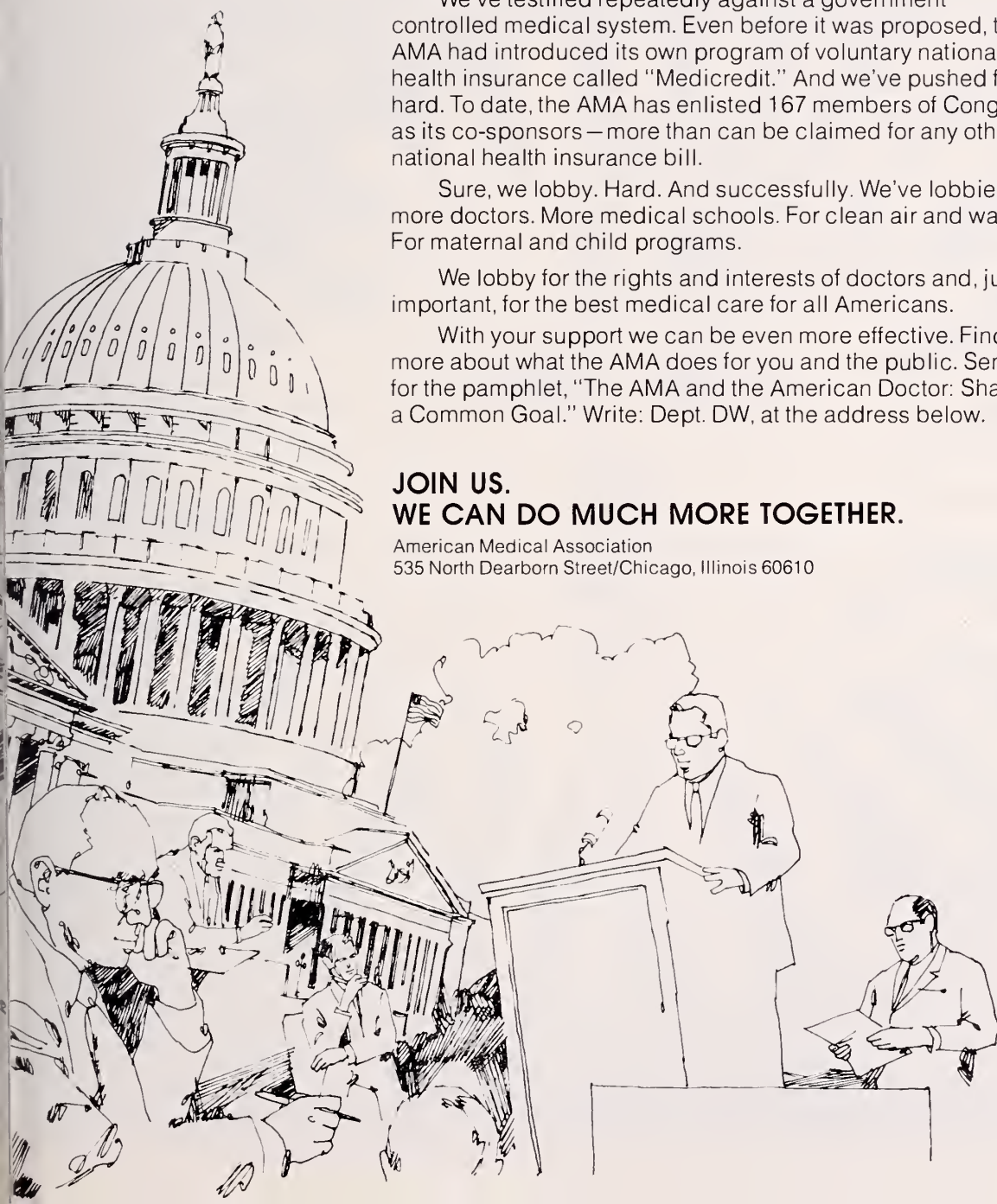
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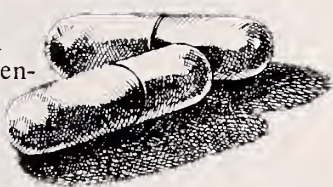
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in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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## Book Reviews

**Acute Cholecystitis** by Clarence J. Schein, M.D., Pp. 354. Illustrated. Price \$17.50, Hagerstown, Md., Harper and Row, Publishers, Inc., 1972.

This monograph on Acute Cholecystitis has some good points to recommend it. References to more than 600 articles and 50 monographs are given. It even includes a list of the movies on the subject and how to obtain them.

Brief biographies of the pioneers and biliary tract surgery are included.

The illustrations, both radiographic and drawings, are excellent.

There are several deficiencies, in the opinion of this reviewer, in this book. Although references are given up to 1970, the exciting articles of Small and others outlining cholesterol-phospholipid-bile salts ratio in the genesis of gallstones are not included. A chapter on radiography of the biliary tract even includes angiography. Yet, transhepatic cholangiography is not mentioned. Material from earlier literature is included somewhat uncritically.

Because of the deficiencies as mentioned above, I believe that the appeal of this book will be somewhat limited.

F. NORMAN VICKERS, M.D.  
PENSACOLA, FLORIDA

**Slim Chance in a Fat World: Behavioral Control of Obesity** by Dr. Richard B. Stuart and Barbara Davis. Pp. 256. Price \$6.00 (Paper cover). Research Press Company, Champaign, Illinois, 1972. Condensed Edition. Pp. 80. Paper cover, \$3.00.

These volumes seem best suited to use with groups. The larger volume reviews the literature on obesity, especially the psychological aspects. Practical suggestions are made for documenting overeating and ways to overcome it.

Even if a physician were not involved in group work, the condensed edition might be helpful if used by a single patient.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Introduction to Neuroscience** edited by Jeff Minckler, M.D., Ph.D. Pp. 420. 661 illustrations. Price \$22.50. St. Louis, The C. V. Mosby Company, 1972.

Since my school days, I have stood in awe of anyone who could master the vast complexities of the brain and nervous system. In the few years I've been associated with neuropathology, I have stood in awe of Jeff Minckler and I know that anything bearing his name **MUST** be good.

This concise, well-written volume offers sizable information to the unindoctrinated student of the neurosciences. It is divided into five parts which follow in logical sequence and cover each discipline of neurobiology (anatomy, development, physiology, chemistry, psychobiology and communications). Each part is subdivided into chapters, 24 in all. Fourteen of these chapters have been written by the editor and this is the strength of the book. Dr. Minckler's style and clarity are unmatched by the nine other contributors.

The overwhelming structure of the volume which one sees very quickly is the portion devoted to neuroanatomy, both gross and microscopic. This consumes 216 pages or more than half of the book for human neuroanatomy. The reader wonders why the book was not titled *Introduction to Neuroanatomy*.

The plates and figures, particularly those in the first portion of the book, are detailed and superb. Unfortunately, and something acknowledged by the editor in the preface, references consist mostly of review titles, leaving the reader with the task of searching for more extensive bibliographies in the cited works. For example, when one looks up a number cited in the text, he finds the reference to be a 520 page book. Specific pages are not listed.

ITN is a useful addition to the growing number of neuroscience textbooks and is recommended to the medical student interested in problems of the nervous system in general and neuroanatomy in particular.

ARTHUR FREDERICK SCHIFF, M.D.  
MIAMI



## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Current Concepts in Radiology** edited by E. James Potchen, M.D. Pp. 346. 502 Illustrations. Price \$24.75. St. Louis, The C. V. Mosby Company, 1972.

**Is My Baby All Right?** by Virginia Apgar, M.D. and Joan Beck. Pp. 492. Illustrated. Price \$9.95. New York, Trident Press, 1973.

**Renal Disease in Childhood** by John A. James, M.B. Pp. 377. 116 Illustrations. Price \$23.50. St. Louis, The C. V. Mosby Company, 1972.

**Family Planning Education, Parenthood and Social Disease Control** by Charles William Hubbard, B.S., M.P.H. Pp. 173. 48 Illustrations. Price \$3.95. St. Louis, The C. V. Mosby Company, 1973.

**Heritable Disorders of Connective Tissue**, 4th Ed. by Victor A. McKusick, M.D. Pp. 878. 1099 Illustrations. Price \$32.50. St. Louis, The C. V. Mosby Company, 1972.

**Current Diagnosis Treatment** by Marcus A. Krupp, M.D. and Milton J. Chatton. Pp. 996. Price \$12.00. Los Altos, Calif., Lange Medical Publications, 1973.

**Mental Health and Social Change, An Annotated Bibliography** edited by George V. Coelho. Pp. 458. Price \$3. Washington, D. C., U.S. Government Printing Office, 1972.

**Cosmetic Facial Surgery** by Thomas D. Rees, M.D. and Donald Wood-Smith, M.D. 609 pages. 1,500 illustrations (35 in color). Price \$55.00. Philadelphia, W. B. Saunders Company, 1973.

**Davis-Christopher Textbook of Surgery**—10th edition, edited by David C. Sabiston Jr., M.D. 2,135 pages. 1,538 illustrations with 6 views in color. Price \$27.50. Philadelphia, W. B. Saunders Company, 1972.

## Deaths

**Astler, DeWitt G.**, Winter Park; born 1898; Eclectic Medical College, 1921; University of Cincinnati College of Medicine; member AMA; died August 24, 1972.

**Beamer, William D.**, St. Cloud; born 1910; Jefferson Medical College, 1937; member AMA; died November 13, 1972.

**Brookins, James Odell**, Tampa; born 1925; Meharry Medical College, 1960; member AMA; died February 6, 1973.

**Ekermeier, Ernest W.**, Tallahassee; born 1906; Cincinnati College of Medicine, 1931; member AMA; died December 2, 1972.

**Hardee, Erasmus B. Sr.**, Vero Beach; born 1898; Medical College of Virginia, 1925; member AMA; died February 18, 1973.

**Hinton, Andrew H.**, Miami; born 1904; University of Georgia, 1930; member AMA; died July 2, 1972.

**Hutchins, Paul F.**, Jacksonville; born 1915; Emory University, 1940; member AMA; died November 3, 1972.

**Moss, Jack W.**, New Port Richey; born 1900; New York Medical College, 1923; member AMA; died December 12, 1972.

**Peek, Cecil M.**, West Palm Beach; born 1915; Johns Hopkins University, 1940; member AMA; died January 14, 1973.

**Snyder, John W.**, Miami Beach; born 1884; University of Michigan, 1906; member AMA; died November 9, 1972.

**Weil, Nathan Jr.**, Jacksonville; born 1912; Tulane University, 1937; member AMA; died December 11, 1972.

**White, Charles M.**, Coral Gables; born 1928; University of Pennsylvania, 1951; member AMA; died March 5, 1973.

**Zeagler, George M.**, Palatka; born 1899; University of Georgia, 1926; member AMA; died January 9, 1973.

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**IF YOU HAVE A FLORIDA LICENSE** and want to work less and play more golf or fish, consider living in Silver Springs Shores (10 miles southeast of Ocala). Openings for radiology, pediatrics, orthopedics, and general practice after July, 1973. Contact Robert C. Bartlett, M.D., 954 S. E. 5th Street, Ocala, Florida 32670. (904) 629-2424.

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**CLINICAL PSYCHOLOGIST:** Diplomate American Board of Professional Psychology; Ph.D. Harvard University; 23 years experience general hospital psychiatry departments, clinics, medical schools. Currently supervising and participating in diverse clinical psychology program of general hospital psychiatry department and clinics, also professor of medical school. Active, excellent health, seeking relocation in Florida. Desires association with group, clinic, hospital, or medical school setting. Prefer southern coastal or gulf areas but will consider all opportunities. Call (201) 762-7653. Write C-591, P.O. Box 2411, Jacksonville, Florida 32203.



CLINIC MANAGER/BUSINESS MANAGER desires change, multi-specialty or medium sized group. Experienced in all phases of accounting, billing, insurance, personnel recruitment, physician recruitment, purchasing, patient flow and ancillary departments. Six years hospital and clinic background. Salary range \$20,000. Write C-590, P.O. Box 2411, Jacksonville, Florida 32203.

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The Florida Medical Association offers placement assistance through the Physician Placement Service, P. O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

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## FLAMPAC AWARD





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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## FLORIDA REGIONAL MEDICAL PROGRAM SUPPLEMENT

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**MAY COVER**—The Florida Medical Political Action Committee received a top membership award during the annual AMA-AMPAC Public Affairs Workshop in Washington in March. William J. Dean, M.D., St. Petersburg (left), President of the Florida Medical Association and Joseph C. Von Thron, M.D., Cocoa Beach, Chairman of FLAM-PAC, proudly display the award. Looking on are William W. Thompson, M.D., Fort Walton Beach; U.S. Rep. Robert L. F. Sikes, Crestview; U.S. Sen. Lawton Chiles, Lakeland, and John W. Glotfelty, M.D., Lakeland. See details on pages 5 and 50.



## President's Page



### Politics and Medicine

Not many years ago, most of our profession would have been in agreement that there was no place for politics in the practice of medicine. Times have changed. At our most recent FMA Board of Governors' meeting, the review of our Council and Committee reports pointed out, among other things, that people are more and more interested in the legislative process as it affects our daily lives in the practice of medicine. Almost all of our committees had something to say about legislation, and many are requesting that the FMA Legislative Bulletin be sent to them each week that it is published. For any of us who are trying to keep up with the day by day changes in the laws that affect our practice, it becomes apparent now that not only our pocketbooks are being affected, but quality and quantity of patient care seems to be falling under the lawmakers' domain.

On Friday, March 9, 1973, over 650 medical leaders gathered in Washington, D.C. at the Washington-Hilton Hotel, for the annual AMA/AMPAC Public Affairs Workshop. This meeting is sponsored jointly by the AMA and AMPAC, which is our political action arm. For two full days, beginning with breakfast meetings each morning, and with dinners in the evening, all of us who had the privilege of attending were exposed to speakers and panels. Republican National Chairman, George Bush and Democrat National Chairman, Robert Strauss, both Texans, agree that they are aiming at the same goals, namely, good and honest government. Both these men were impressive, and I believe we are headed for a stronger and better two-party system. Highlights of anticipated medical legislation for the coming year were explained and presented to us by several Congressmen and Senators, and there is no secret that health care has become big business in this country and commands a tremendous amount of our national budget each year—about one dollar out of fourteen in our Gross National Product is spent on some type of health care.

After the close of the National Workshop, the Florida delegation met on Monday, March 12, with our Florida Congressmen and Senators. Each key contact position called on his respective legislator, and then we had lunch for our legislators in a private dining room in the Rayburn Office Building. This face to face discussion concerning our mutual problems is all important. I must point out that the Washington office of the AMA does a fantastic job representing us before Congress. These men are true specialists in their field. When they briefed us concerning national legislation, it was quite obvious that our AMA lobbyists and advisers are on top of the situation and working for us literally day and night. As we are professionals in our chosen field of medicine, they are obviously professionals in their chosen field.

I am writing this President's Page not so much to report to you the activities of your National Legislative Committee and Congressional Visitation, as to point out the importance of political action today. With the number of bills both in Tallahassee and in Washington concerning medical care of our patients, it becomes apparent that we must remain active daily in producing input into this legislative process. The importance of keeping our local state and national representatives informed of our feelings cannot be overly stressed. In addition, we must depend upon our professional employees, the AMA Public Relations Department in Chicago and Washington, to carry out and advise us in dealing with the legislature at that level. I do hope that any of you who are not currently members of both FLAMPAC and AMPAC will see fit to join and provide this bit of monetary support to our cause. This money could not be better spent.

As I write this last of my presidential reports to you, I can't help but look back over the year and feel that it has been a good year. We have been busy meeting day by day challenges as well as planning for the future. My one plea to the doctors of Florida is that we stick together and remain strong by virtue of unity. We cannot afford to be fractionated at a time when we must pull together as one team. Thank you for allowing me to communicate my thoughts to you over the past year.

*William J. Dean, M.D.*

# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis, parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of Ascaris in the mouth and nose. Hypersensitivity reactions



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The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



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patient... for *intravaginal use*. By cutting off the tip  
of the narrow soft end, the contents can be extruded  
through an intact hymen for *intravaginal use*. And  
it is readily adaptable to *topical application* for  
labial involvement, and/or *intravaginal use* to treat  
mucosal infection.

## **CANDEPTIN (candicidin) provides:**

### **Rapid results**

Prompt, symptomatic relief — itching, burning,  
and discharge subside in 48-72 hours!

Soothing, miscible ointment permits complete  
contact with affected tissue.

Usually cures in a single 14-day course of therapy.<sup>2,3,4</sup>

## **Safe**

Exact dosage assured.<sup>2,3</sup>

No side effects, clinical reports of irritation or  
sensitization extremely rare.

## **Convenience**

Easy to use intravaginally and/or topically  
for labial involvement.

Encourages patient acceptance and cooperation.  
Therapy is easy to start in your office.

## **Clinical proof of potency**

CANDEPTIN (candicidin) is significantly more potent  
*in vitro* than nystatin.<sup>5</sup> CANDEPTIN Vaginal Ointment  
and Tablets have a clinical record of cure rates  
of 90% and more in pregnant and non-pregnant  
patients!<sup>1,4,6</sup> In recent studies on CANDEPTIN  
VAGELETTES Vaginal Capsules, involving both gravid  
and non-gravid patients, a 100% culture-confirmed  
cure rate was achieved with a single 14-day  
course of therapy.<sup>2,3</sup>

## **Unique**

**CANDEPTIN<sup>®</sup> (candicidin)**  
**VAGELETTES<sup>™</sup> Vaginal Capsules**

**Description:** CANDEPTIN (candicidin) Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate. CANDEPTIN VAGELETES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.

**Action:** CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETES Vaginal Capsules possess anti-microbial activity.

**Indications:** Vaginitis due to *Candida albicans* and other *Candida* species

**Contraindications:** Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

**Caution:** During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

**Adverse Reaction:** Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETES Vaginal Capsules have been extremely rare.

**Dosage:** One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

**Available Dosage Forms:** CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN VAGELETES Vaginal Capsules are packaged in boxes of 14 (14-day regimen requires 2 boxes.)

Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

**References:** 1. Olsen, J.R.: *Journal-Lancet* 85:287 (July) 1965. 2. Giorlando, S.W.: *Ob/Gyn Dig.* 13:32 (Sept.) 1971. 3. Decker, A.: Case Reports on File, Medical Department, Julius Schmid. 4. Giorlando, S.W., Torres, J.F., and Muscillo, G.: *Am. J. Obst. & Gynec.* 90:370 (Oct. 1) 1964. 5. Lechevalier, H.: *Antibiotics Annual 1959-1960*. New York, Antibiotics Inc., 1960. pp. 614-618. 6. Friedel, H.J.: *Maryland M.J.*, 15:36 (Feb.) 1966.

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**CANDEPTIN®**  
(candicidin)  
**Vaginal Tablets**  
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**and VAGELETES™**  
**Vaginal Capsules**



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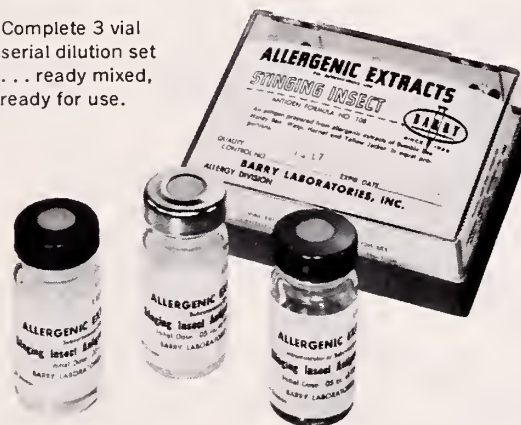
*protection for patients  
who have had severe  
reactions to stings of  
BEES, WASPS, HORNETS,  
YELLOW JACKETS*

Serious complications can and do arise in persons hypersensitive to stings of these insects. Persons showing sensitivity usually show a *progressive* increase in the severity of reactions to subsequent stings.

Barry STINGING INSECT ANTIGEN No. 108 (allergic extracts) is a combined insect antigen designed to protect patients from severe reactions to future stings by immunization. This balanced stock formula is a polyvalent whole-body extract of wasp, hornet, bumble bee, honey bee and yellow jacket antigens; and offers cross protection against stings of any of these insects.

For administration and dosage see prescription package circular.

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... ready mixed,  
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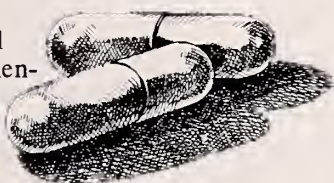




**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

## **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



## **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis**

**adjunctive Librax®** 

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Nutley, New Jersey 07110

## Medical News

### Medicredit Gets 127 Sponsors

The American Medical Association's Medicredit Plan for national health coverage had attracted 127 congressional sponsors by January 1, 1973—16 senators and 111 representatives.

Florida co-sponsors, according to AMA, are Sen. Edward Gurney, a Republican; Democrat Reps. Bob Sikes, Don Fuqua, James A. Haley, and Dante B. Fascell; and Republican Reps. C. W. Bill Young, Louis Frey Jr., and J. Herbert Burke.

AMA's proposal was reintroduced in the Congress as H.R. 2222 in the House of Representatives and as S. 444 in the Senate on January 18.

### Seminar on Water Sports Injuries

The American Academy of Orthopaedic Surgeons will sponsor a course on the prevention and treatment of water sports injuries at the Americana Hotel on Miami Beach, May 25-27.

Three days of lectures and panel discussions will cover drowning, competitive water sports, scuba diving, boating accidents, dangerous marine animals and water sports for the handicapped.

Information may be obtained by contacting the American Academy of Orthopaedic Surgeons, 430 North Michigan Avenue, Chicago, Illinois 60611.

### ABFP Certification Examination

The American Board of Family Practice announces that it will give its next two-day written certification examination on Oct. 20-21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing to Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

*Please Note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is Aug. 1, 1973.

### Medical Unions

Six Medical Unions have ratified a constitution and bylaws for a national union known as the American Federation of Physicians and Dentists. Stanley S. Peterson, M.D., Springfield, Mo., an AMA delegate, was elected president of the union which claims to represent 8,000 physicians and dentists. Donald C. Meyer, D.D.S. New York, was named first vice president. Dr. Peterson said the union would act as "a strong bargaining agent with third parties." Temporary headquarters is in Springfield, Mo. Seven other medical unions, all chartered by the AFL-CIO, refused to join the AFPD because it did not provide for affiliation with organized labor. These unions have set up their own National Council of Physicians' Union within the Service Employees International Union, AFL-CIO. John L. Holmes, M.D., Las Vegas, was elected president. He said his union is "committed to the concept that physicians must align with organized labor."

### FMA Speaker

U.S. Sen. John G. Tower (Rep.-Texas) will be a headline speaker at the 99th Annual Meeting of the Florida Medical Association this month.

Sen. Tower, one of the Senate's leading conservatives, will speak at the Auxiliary-FLAMPAC luncheon at 12:15 P.M. on Friday, May 11, at the Americana Hotel, Bal Harbour.

The Texas Republican began his Senate career 12 years ago. Prior to that, he was a member of the faculty of Midwestern University.

A native of Houston, Senator Tower received a B.A. degree from Southwestern University and an M.A. at Southern Methodist University.



# The University of Miami School of Medicine's Thirty-Three Month Curriculum

E. M. PAPPER, M.D.

After a long period of thorough planning, the University of Miami School of Medicine will implement a thirty-three month medical education program in 1973. Since the AMA-AAMC Committee on Accreditation requires that students complete at least 32 months of instruction within a three year period, the 1973 entering freshman class will begin school on 6 July 1973 rather than September of 1973.

The introduction of this program at the University of Miami School of Medicine follows the path of some 26 other Schools of Medicine and is in keeping with the needs of the people and the trend of the times. Other schools have indicated similar intentions. Moreover, the projected period of medical education has been a common pattern in Europe. In many countries, the education of physicians (combined premedical-medical education) takes place in a period of six years.

Although there is a great deal of controversy concerning the shortening of medical education, there are many cogent reasons for implementing this kind of program. First, the average physician who takes specialty training must commit himself to a total of twelve years of educational training. This period does not include the usual two year obligation to the military or Public Health Services. Therefore, students graduating from high school at eighteen years of age cannot usually go into medical practice until they reach the age of thirty to thirty-two. Eighty percent of physicians presently attend college for four years, then four years of medical school, spend a year in internship and anywhere from two to five years of residency training.

Another reason for the acceleration of medical training is the cost of this lengthy process. Most private universities and schools of medicine have annual tuition in excess of \$2700.00 per year, with

some schools as high as \$3,000.00. These expenses coupled with the present cost of living means that the typical single student or his family will have to spend a minimum of \$5,000-\$6,000 per year for bare essentials during their education. Over an eight year period this amounts to at least \$40,000. The cost to the individual is greatly over matched by the medical school. Analysis of the University of Miami School of Medicine's cost of education indicates that the tuition of \$2,300 is only approximately 20 percent of the actual expense incurred for each student. Although the Carnegie Commission on Higher Education stated that shortening the curriculum would reduce the medical school's cost, this judgment is probably inaccurate. The buildings, faculty and administrative staff must be maintained at the same level or actually increased. In truth, the major financial saving is to the students themselves; both in terms of time and money—and this factor is important.

It is necessary to raise the question whether the thirty-three month curriculum will compromise the quality of medical education. There is no question that the huge mass of scientific and medical knowledge have grown almost uncontrollably during the last two decades. We are reconciled to the fact that all this knowledge cannot and probably should not be taught. Important concepts and principles rather than simple transfer of information must be taught to students.

Since many schools do not begin until mid or late September, and finish in May, the actual amount of total time involved in a four year program is 44 months. Most schools have at least eight months of summer vacation in the 4 year period. Therefore, only thirty-six months are available for instruction. This estimate includes at least an additional month of vacation (winter and spring holidays) each year, and extensive elective periods which most schools have found to be completely unsatisfactory in their present

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.



formats. These data suggest that there is considerable room for a more efficient pattern of education without reducing the amount of teaching contact time or compromising the quality of education. These factors do not take into account the significant advantages that have been made in medical technology in improving the teaching—learning process.

Some of the arguments against shortening the curriculum include the following: 1. Students require free time to earn money during the summer; 2. The accelerated curriculum will put considerable pressure on the individual student; 3. There is a minimum amount of time that is required for student to mature and cope with the problems of caring for sick people; 4. There is not enough assimilation learning time in an accelerated teaching program; 5. The degree of flexibility in the entire process is significantly reduced.

Of all the problems, the most crucial one is need for emotional maturation of the student. We believe that the relatively long residency process, where maturation really takes place, will answer this very important concern.

The amount of instructional time in the new curriculum will not be reduced from the present program. Students will have adequate assimilation time, (self-study), review periods for examinations, early introduction to the clinical disciplines, an improved but shortened elective period and periodic, but less extensive vacations which will allow the School to meet the accreditation requirements.

It is essential to stress that the new curriculum takes advantage of the educational changes that have evolved during the past six years. Our Curriculum Committee is convinced that the present curriculum is a very good one. The Committee recognizes that the evolution of a sound training program is not the sole result of its deliberations and planning. It is the cumulative effect of a strengthened Administration, excellent Basic Science Departments, a magnificent student body and improved educational technology; especially biomedical communications.

The beginning date for freshman students in the new program will be 6 July 1973. During the first 14 weeks the students will be offered courses in Gross Anatomy, Embryology and Basic Tissues, Biochemistry and Introduction to Medicine. Some students will have an opportunity to take an

advanced Biochemistry course offered to certain students who are capable of passing a standardized achievement test in that discipline. After a week's vacation, students will take an 8½ week interdisciplinary course in the Neurosciences. They will have a 14 week program in Systemic Biology (after their two week winter holiday). This course will be taught along Departmental lines (Histology, Biochemistry III, Physiology and Pharmacology) but there is a maximum of integration and a minimum of reduplication. This is followed by a 15 week Sophomore Core program.

In July the students will have a three week vacation prior to the beginning of their 14 week integrated Mechanisms of Disease course. In late November, the sophomores will be given an official (in-house) Part I of the National Boards, with adequate free time for review. Students will be required to pass this examination and perform adequately in their course work prior to promotion to the clinical training program.

In January, students will begin their clinical rotations. The Core Clinical Curriculum will be the same as presently offered (i.e., Medicine—12 weeks; Psychiatry—6 weeks; Neurology—4 weeks; and Anesthesiology—2 weeks). Two weeks will be provided in June to review and take Part I of the National Board of Medical Examiners (official test for licensure). Two weeks will also be allowed for a winter vacation. Following the required clinical training program, students will have to face months of elective training; one of which will be in Clinical Pharmacology. The new elective program will be more selective and structured than previous years. Part II of the National Board of Medical Examiners will be taken in April prior to graduation in June.

Although there will undoubtedly be problems especially in the transitional period, the School of Medicine is confident that the new curriculum will permit the graduating of well qualified physicians in a shortened period of time and with greater efficiency. Only an accurate longitudinal evaluation of an accelerated medical training program will ascertain whether or not this trend in education is desirable. Our School of Medicine intends to evaluate all of its programs; the regular four year training program, the 33 month program as well as the Ph.D. to M.D. program.

► Dr. Papper, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami 33152.

"...a more satisfactory treatment..."<sup>1</sup>



# VITAMIN C

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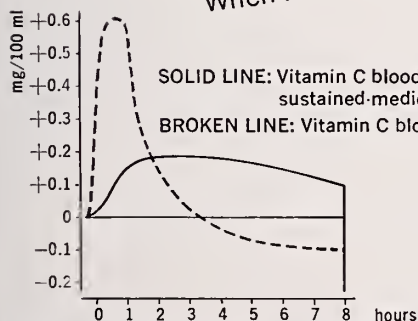
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CEVI-BID Capsules permit convenient, b.i.d. dosage for more predictable, sustained vitamin C blood levels all day and night. This avoids the "peaks and valleys" that result from ordinary vitamin C intake (wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels). The unpredictability of enteric-coated vitamin C is also avoided. Cevi-Bid's unique micro-dialysis principle provides release of 500 mg. of vitamin C during a 12 hour period at a smooth, uniform rate.

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\*Adaptation

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<sup>1</sup> Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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# What's on your patient's face...

may be more important than his chief complaint

Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J





# The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

## Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

## Sequence of therapy— Selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

## Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



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# This patient's lesions were resolved with

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## **Medical News**

### **Eye Department at Miami Endowed**

Mr. and Mrs. Willaford R. Leach of Palm Beach have endowed a chair in the Department of Ophthalmology at the University of Miami School of Medicine in the amount of \$1 million. Mr. and Mrs. Leach with their friends have donated funds sufficient to defray about a third of the cost of a new eye hospital at Miami.

### **Dr. St. John Joins Blue Shield**

J. H. St. John, M.D., of Jacksonville, has been named Associate Medical Director of Blue Shield of Florida.

In this assignment, Dr. St. John will work with Thomas M. Irwin, M.D., Director of the Medical Division. The new Associate Director was Chief of the Department of Medicine at Jacksonville's St. Vincent's Hospital from 1967 to 1972.

### **18th Central Florida Medical Meeting**

The Orange County Medical Society's 18th Annual Central Florida Medical Meeting will be held at the Contemporary Hotel at Disney World, June 1-3.

The program will include seminars on neurology and thrombotic disorders; medical and surgical management of arthritis, and hypertension, edema and coronary artery disease.

Fees include \$50.00 for members of the Florida Medical Association; \$100.00 for others. Interns and residents will not be charged if they have a letter from their chief of service.

Additional information may be obtained by writing to the Orange County Medical Society, 800 North Orange Avenue, Orlando, Florida.

### **PSRO Regulations**

The Administration is fully cognizant of the fact that PSRO can not operate without the cooperation of the medical profession, and nothing having to do with PSRO "has been cast in concrete." A memorandum sent by the Social Security Administration's Bureau of Health Insurance last month to its regional offices outlines the regional offices' responsibilities in evaluating and monitoring PSRO demonstration projects and is complete with detailed guidelines. PSRO regulations, however, have not yet been written, commented Charles Edwards, M.D., Assistant HEW Secretary.

### **References to Medical Journal Articles Available**

References are almost instantly available to physicians through a new service of the National Library of Medicine, National Institutes of Health. Called MEDLINE, the service is coordinated by 11 regional medical libraries and involves a network of some 120 libraries in health-related institutions, primarily medical schools. A data base at the NLM contains 400,000 citations to articles from 1,200 journals. Access to the data base computer is by toll-free teletype in 45 cities. Users elsewhere will pay long distance telephone charges to the nearest of the 45 cities. Direct inquiries to Associate Director of Library Operations, National Library of Medicine, 8600 Rockville Pike, Bethesda, Md. 20014.

### **Eighth Inter-American Conference**

The University of Miami School of Medicine has announced it will sponsor the Eighth Inter-American Conference on Toxicology and Occupational Medicine at the Key Biscayne Hotel in Miami, July 8-11.

A registration fee of \$30 will be charged. Information may be obtained from Rafael A. Peñalver, M.D., Director of International Medical Education, University of Miami School of Medicine, Suite 1910, Sheraton-Four Ambassadors, Miami 33131.

# FEEDBACK -from Pearl Street

## Virus Disease Surveillance—

Most important in the surveillance of virus diseases is the physician's high degree of suspicion that a viral etiology is possible. Since symptomatology may not be the last word, the laboratory must be called upon for assistance. The physician should heed his suspicion and order a serum specimen when the patient first presents himself, or at least within the first few days. A stool specimen is necessary when an enterovirus is suspect. The lag in the state laboratory's report on virus isolation is proportional to the time between collection, shipment and receipt of specimens. The entire procedure is an exercise in futility unless proper and timely specimens are submitted, accompanied by a relatively complete medical history. The personal physician has the major responsibility for a tentative diagnosis and ordering the appropriate laboratory procedures, but his acuity is wasted unless the nurses and technicians collect and ship the necessary specimens promptly.

## Gonorrhea Infections—

The screening program for detection of gonorrhea infection among asymptomatic female patients moves forward rapidly, reflecting the concern among medical disciplines about this problem. The number of cultures submitted to state laboratories continued to increase the first part of the year. The casefinding program was responsible for more than a 100% increase in cultures in 1972; the percent positive dropped to 11.6 from 13.3 in 1971. No doubt this was influenced by cultures obtained from asymptomatic patients representing differing socioeconomic levels in the community. A contributing factor is acceptance of the "Transgrow" transport culture diagnosis for presumptive evidence of infection. This medium comes ready to use in screw cap bottles containing a partial atmosphere of carbon dioxide. Adequate growth of gonococci may be expected even after delays in shipment up to 72 hours. This technique yields results comparable to the conventional culture method and is available through most private and hospital laboratories.

## Pesticide Poisoning—

The Community Studies on Pesticides based in Dade County ended on an optimistic note. This type poisoning in children no longer poses a serious problem. Legislation made parathion illegal in the county and public awareness of possible danger solved the problem of the illicit peddler. The case fatality rate for parathion poisoning declined to zero in 1972 indicating improvement in clinical management.

The aerial crop duster, swamper and agricultural applicator are most highly exposed to pesticides. These men are mobile and their exposures intermittent. Interpretation of the effects of the pesticides on their health is circumscribed but the conclusion is that there is no valid reason at present to lower the residues therapeutically. Diphenylhydantoin removes trace amounts of DDT, its metabolites and dieldrin from the tissues. Technical improvement in the formulation and manufacture of pesticides means that these groups no longer are so heavily exposed.

DDT and its metabolites are at a higher level among blacks than whites, and residues appear to be clustered in families. Incidental exposure in the urban areas is greater among the less affluent. This exposure is largely from nondietary sources.

In patients with cancer concentrations of DDT, its metabolites and dieldrin are no different than in patients undergoing elective surgery.

DDT has been around for 24 years. There are many who believe that environmental carcinogenesis may have an induction period of as long as 30 years. The question, therefore, as to whether these pesticides are ever carcinogenic cannot be definitively answered at this time.

## Typhoid—Dade—

The largest outbreak of typhoid fever in the U.S. since 1939 is apparently over. As of 28 March 181 cases have been confirmed, with another 60 still under consideration and undergoing diagnostic tests. No cases with onset date later than 15 March have been reported. All except one have direct association with the water supply at the South Dade Labor Camp.



# Two forms of Cordran® Flurandrenolide



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300060



## Growing Fractures in Children

ROBERT F. CULLEN JR., M.D., AND LARRY K. PAGE, M.D.

**Abstract:** Growing fractures are uncommon following head trauma in infants and children and occasionally result in mental retardation, seizures or hemiparesis. Physicians should be aware of this entity and follow-up skull x-rays are recommended on all diastatic skull fractures in childhood. Early surgical closure offers the best current therapy.

Growing fractures have been reported as "leptomeningeal cyst," "craniocerebral erosion," and "posttraumatic meningocele." They have been described in humans and simulated in an animal experimental model using puppies.<sup>1,2</sup> A thorough review of the world's literature and clinical description of the syndrome was presented in 1961 by Lende and Erickson.<sup>3</sup> Our present report serves to remind physicians of these uncommon fractures of infants in the hope that appropriate therapy may be promptly instituted.

### Report of Case

This 7-month-old female infant sustained a linear right parietal skull fracture and subsequent subgaleal hematoma formation at age three months following a fall (Fig. 1). The hematoma resolved and no neurological deficits were noted. At age six months a fluctuant, pulsatile mass was

seen over the right parietal area, and follow-up skull x-rays showed an enlarging fracture (Fig. 2). Examination showed a 2 x 4 cm defect in the right posterior-parietal bone with a protruding, soft, pulsatile mass. The rest of the examination was unremarkable. At operation, the bony defect was enlarged to expose the retracted edges of the dural laceration. There was localized brain atrophy as exhibited by narrowed gyri and deepened sulci. Meningocerebral adhesions were gently freed. A watertight closure was then obtained by using a patch graft of freeze-dried homologous dura mater. Small bits of bone from the craniotomy were placed over the dura within the skull defect (Fig. 3). At follow-up examination two months later, she was doing well without neurological deficit and with a cosmetically good result.

### Discussion

The case described here has the common features associated with this syndrome: (1) a parietal skull fracture occurring in early infancy or child-

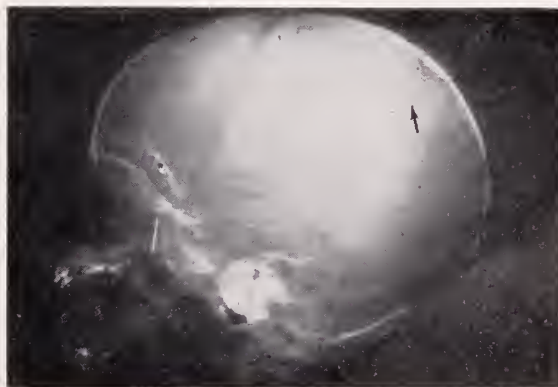


Fig. 1.—Arrow denotes diastatic parietal skull fracture.

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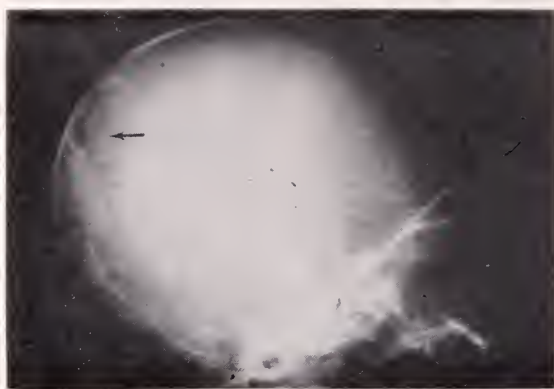


Fig. 2.—Arrow denotes enlargement of original skull fracture.

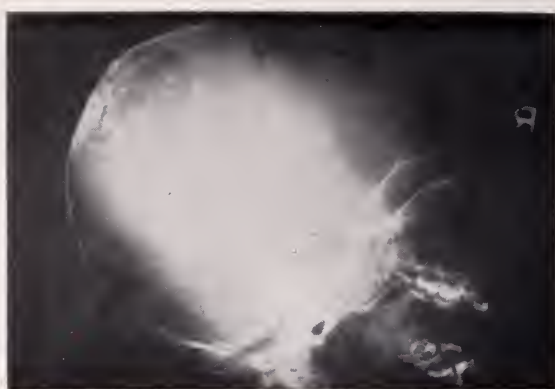


Fig. 3.—Postoperative repair. Note bone chips present in dura over the craniotomy site.

hood, (2) an unsuspected dural and arachnoid tear at the time of fracture and (3) subsequent enlargement of the fracture to form a cranial defect. Other reported features have included ventricular enlargement beneath the fracture site and herniation of the underlying brain. Occasionally a cephalohydrocele may form over the fracture or a cyst may form within the underlying brain. Seizures, hemiparesis and hemiatrophy have also been noted and are probably related to underlying cortical injury from the initial trauma and/or secondarily from the pressure of the expanding cyst.

The first report of this condition was in 1816 by John Howship.<sup>2</sup> Rokitsansky in 1856 described the autopsy findings of an 8-month-old who died with meningitis complicating puncture of the sac.

Growing fractures usually occur within the first year of life following head trauma and there is often a significant time lapse between the actual injury and the discovery of the bony erosion. Presenting symptoms may suggest a tumor with increasing intracranial pressure and with underlying cortical injury, seizures or hemiparesis can result. There is nothing unique about the manner of head injury. The fracture that results is on the vault of the skull and a certain degree of diastasis or separation of the edges of the fractures is usually present. The location is predominantly in the parietal bone and frequently the overlying scalp is not broken at the time of injury. There appears to be no relationship between the development of a cyst and the severity of the original injury. Both the inner and outer tables are involved and the wider the original fracture, the greater the subsequent possible formation of a leptomeningeal cyst.

The radiological characteristics of the syndrome include widening of the old fracture, scalloping and sclerosis of the bordering inner table of the skull, and localized increase in vascularity of the bone.<sup>4</sup> The initial defect is usually irregular or lens shaped with the long axis over the fracture line. Subsequent enlargement of the fracture occurs only in children and may develop rapidly within two months. The cyst itself often is not visible on a plain radiograph and if deep seated, may not be recognized.<sup>5</sup> Goldstein has demonstrated experimentally that both the dura and arachnoid must be opened for an enlarging skull fracture to occur. Taveras and Ransohoff<sup>6</sup> felt that with a skull fracture, an underlying dural tear and diminished CSF absorption secondary to subarachnoid hemorrhage, the arachnoid membrane probably projects out through the dural laceration into the fracture site where it becomes trapped. Normal brain pulsations then produce a gradual erosion of the bony edges and at the same time compress the underlying cortex. This ball-valve mechanism allows a greater ingress of cerebrospinal fluid and the effects of the pulsatile cerebrospinal fluid produces a bony erosion much like that seen with an aortic aneurysm. It is not the simple pulsation of fluid against bone but rather of fluid pulsating within a cyst or pouch that produces the higher incidence of bony erosion.<sup>7</sup>

These lesions must be distinguished from an epidermoid cyst, eosinophilic granuloma, cephalohematoma, halisteresis, or a subepicranial hydrocele. Transillumination may be of help and a pneumoencephalogram may show focal ventricular enlargement beneath the site of injury or occasional cerebral atrophy in cases of long standing.



There may be a porencephalic communication as well with the ventricular system.<sup>8</sup> At surgery, the dura has retracted well back under the bony margins and is adherent to the underlying arachnoid. The entrapped fluid is clear and colorless and chemically identical with cerebrospinal fluid. The cyst is removed and adhesions to the free edges of dura are lysed. A water-tight dural closure is paramount and often requires a dural graft. Children less than one year of age with moderate to small bony defects behind the hairline, e.g., in the usual parietal location, do not need a formal cranioplasty plate. The bits of bone ronguered from the edges of the defect in order to expose the dura are scattered over the dural closure and firm bony union follows. The older child or the child with a very large or a forehead defect should have a

plastic or a metal plate inserted. It is important to remember that surgery may not necessarily help the seizures or hemiparesis if they are secondary to direct cortical contusion or laceration.

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On March 19, 1973, the FMA Council on Medical Economics received the following "Statement of Understanding," published by the Illinois State Medical Society in consultation with their legal counsel. The Council recommends that this statement be printed in the Journal of the Florida Medical Association as information for interested physicians:

STATEMENT OF UNDERSTANDING

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

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# Rhinolith

## An Unusual Cause of Septal Perforation

WILLIAM S. TEACHEY, M.D., AND RAYMOND O. SMITH JR., M.D.

**Abstract:** Rhinoliths, intranasal mineral deposits, develop around long-standing foreign bodies, and present with recurrent sinusitis, epistaxis, and malodorous discharge. Treatment is piecemeal removal via anterior rhinoscopy. A case of a large rhinolith causing a septal perforation is presented.

Rhinoliths, rarely-occurring mineral deposits, are thought to develop around long-standing nasal foreign bodies.<sup>1</sup> They usually occur unilaterally; however, in eight of the over 400 cases reported the rhinoliths were bilateral.<sup>2</sup> The foreign body nidus (classified by some as endogenous, e.g., bacteria, or exogenous, e.g., pencil eraser) includes a local chronic inflammatory reaction which is accompanied by the deposition of minerals, primarily salts of calcium, sodium, magnesium and oxalate.<sup>1-3</sup> An unexplained female preponderance has been reported.<sup>1-4</sup>

Patients with rhinoliths usually present with unilateral mucopurulent, malodorous nasal discharge; other common problems include nasal obstruction, recurrent sinusitis and epistaxis.<sup>2-4</sup> Asymptomatic rhinoliths have been reported but they are rare.<sup>5</sup>

The obvious treatment is removal of the rhinolith. Because of their size, some must be removed in a piecemeal fashion after crushing. General anesthesia is occasionally necessary in adults and is frequently required in children.

We have recently treated a patient with a rhinolith which caused a septal perforation and have found no prior reports of septal perforation with this etiology.

### Case Report

A 72-year-old Negro man was admitted to the Gainesville, Florida, V.A. Hospital in September, 1971, with an 18-month history of bilateral, malodorous, purulent rhinorrhea and recurrent sinusitis. The patient gave no history of nasal surgery or trauma. Following removal of purulent nasal secretions, an encrusted, gritty mass was encountered in the midportion of both nasal airways. Only small pieces of the mass could be removed due to epistaxis and patient discomfort during manipulation. Routine roentgenograms revealed opacification of the paranasal sinuses, and tomograms indicated a defect of the bony and cartilaginous septum. The VDRL was nonreactive.

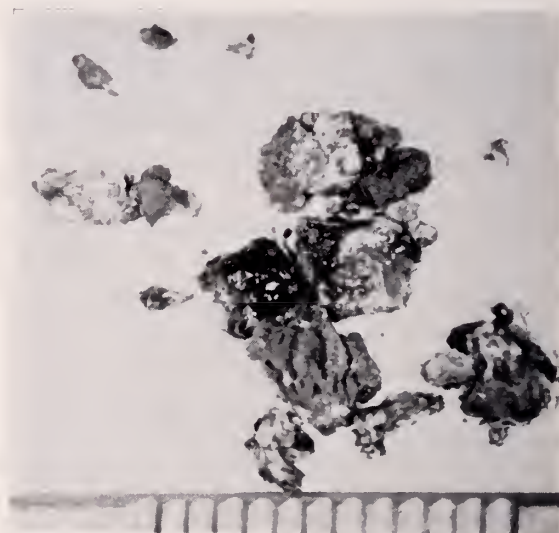


Fig. 1.—Crushed pieces of rhinolith.

With the patient anesthetized, anterior rhinoscopy revealed a semisolid, 3x3.5 cm. mass which occluded both nasal airways. The two lateral portions of the gritty mass were continuous through a 2 cm. midseptal perforation, thereby making removal difficult. After crushing the rhinolith it was removed in pieces and was sent for routine pathologic evaluation (Fig. 1). Biopsies taken from the edematous granular rim of the perforation and the adjacent turbinates demonstrated only chronic inflammatory reaction with granulation tissue. Fungal stains revealed numerous aspergillus organisms. Postoperatively the patient began an almost immediate course of rapid improvement which has continued to date.

### Comment

Since this patient presented no history suggestive of a previous septal perforation, the assumption that the perforation resulted from the rhinolith appears reasonable.

A case is reported in which a large rhinolith apparently caused a nasal septal perforation.

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# The Biologic Time Clock

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**Abstract:** Life is an intrinsic rhythmic experience turned on by the cosmos. Good health is the harmonious integration of body cycles. A disorder may cause an error in timing. A disease may produce a pathological response to faulty timing.

In the future, chronophysiology, chronopathology, and chronotherapy will assume more importance. The physician will probably order a "chronogram" as he now orders a chemical survey. With an individual's rhythmicity plotted graphically, the doctor will have a valuable addendum to his dossier to diagnose and treat a patient.

We are now entering a new and exciting era in diagnostic and therapeutic medicine. It may be called the "Age of the Biologic Time Clock," possibly the "Age of Biologic Rhythms." These rhythms (chronobiology) have been around for millions, possibly billions, of years. Only recently have scientists begun to seriously investigate them.

Knowledge being gained from these investigations will greatly alter our present and future diagnostic thinking and therapy. Medicine will be more biologically scientific. It was once believed that physiologic values were constant in healthy people or animals and only altered in disease. Now it is apparent that the normal body is in a dynamic state of unstable equilibrium and physiologic values are not stabilized at a constant level. For example, blood pressure, blood chemistry, body temperature, and other biologic functions are in different phases at any given hour of the day, yet there is an appearance of a steady state.

We are learning that the homeostatic forces which control our bodies are subject to definite cyclical rhythms. These "Biologic Moods," if I can call them such, are affected by cosmic stimulation, probably brought about by an evolutionary adaption to a rotating earth with alternating periods of light and darkness. There are rhythms in our bodies which vary from the microseconds of enzymes to the 90 minute cycles of sleep. In addition there are weekly, monthly, seasonal, and even yearly cycles.

Unperceived rhythms exist in the world around us as well as in ourselves. We live in a maze of fluctuant activity caused by terrestrial gravity, electromagnetic force fields, atmospheric pressure, alternations of light and darkness, solar flares, solar and lunar gravitational pulls.

Dr. Franz Halberg,<sup>1</sup> the famous chronobiologist, has coined a nomenclature for describing biologic periodicity. "Circadian" rhythm refers to a cycle of about a day and is derived from the Latin "circa" meaning "about" and "dies" meaning a "day." "Ultradian" rhythm is shorter than circadian, and "infradian" is longer. Men and animals demonstrate a circadian rhythm in body temperature, blood pressure, pulse, respiration, blood components, urine excretion, enzyme production, and biochemicals in the nervous system. In health there must be a coordinated ebb and flow in our circadian rhythms, for they make up the biologic time clock which motivates our daily drives, our rest, our ever-changing moods, and our dreams. Although to outward appearance we may seem unchanged, actually we are not the same individual from minute to minute or hour to hour.

Because of these circadian oscillations, a creature's resistant and weak phases, and even its life, are dependent upon the biological time of day. The ability of an experimental animal to survive is determined by the time of day it is given x-rays, bacterial or viral organisms, or drugs. Strangely, even a stimulus, such as a loud noise, will not affect a rodent when resting, but during a period of activity it may drive the animal into a state of frenzy, convulsions, or even death.

Interesting observations have been noted in man. The ability to perform physically and psychologically fluctuates at different hours. Pregnant women go into labor more frequently at night or in the early morning hours. More coronary attacks occur at these times too. Symptoms of disease and deaths are periodic also and not evenly apportioned over a 24 hour period.

Other intriguing data have been discovered. Pengelley<sup>2</sup> and his associates in studying data on a man for 16 years noted his urinary 17-ketosteroids had a daily, weekly, 20 day, monthly, and



an annual rhythm which showed a low in May and a high in the fall and winter. Some psychotics show an annual rhythm of manic depressive attacks. These findings indicate a possible circannual time clock. Curiously the thyroid secretes a summer hormone to reduce body heat, but very little is known about how or what causes its production.

Little is understood about "Spring Fever" or why ulcers, allergies, and some psychoses flare in the spring. The mysterious "Winter Madness" of Eskimos has mystified scientists, but Bohlen's<sup>3</sup> recent studies have disclosed that Eskimos excrete eight to ten times more calcium in winter than in the summer. Suicides peak in May, arteriosclerotic deaths in January, and accidental deaths in July and August. The latter probably bear a relationship to vacations and also seasonal changes.

While the earth alternates between light and dark, living creatures alternate between activity and sleep. This is the most obvious of all circadian swings. Without proper sleep, a man concentrates and performs poorly, becomes irritable and even acts psychotic.

Unsuspected rhythms have been discovered in humans. There is a cyclic variation between the retention and excretion of salt and water every few days.<sup>4</sup> Diuretics are effective at the peak of retention and ineffective at the nadir. There are motor movements of the stomach<sup>5</sup> in a fasting person every three hours which last for 20 minutes. A cholinergic drug is ineffective at the end of this period.

Body temperature varies about  $1\frac{1}{2}$  to 2 degrees daily, being lowest between 2-6 a.m., and highest between 1-7 p.m., when the average individual's mental and physical efficiency peaks. Body temperature and efficiency are closely related. There are "morning people" who rise early, work, and learn best in morning hours. Their temperatures peak before noon. "Evening people" are maximum performers in late afternoon or early evening, and their temperatures peak during these periods. Metabolic processes accelerate at higher temperatures.

Rhythmic tides appear in the blood.<sup>6</sup> Neutrophils reach their high tide during the day, and eosinophils and lymphocytes at night, monocytes and erythrocytes in the evening. Blood proteins are rhythmic too. Gamma globulins alternate as much as 28% and mucoproteins as much as 41% in 24 hours. Gamma globulin levels are highest

in the rat during their last six hours of circadian activity.

Blood pressure is a rhythmic function, reaching its summit around the middle of our sleeping period, and then receding. There is no fixed level of normal or hypertensive blood pressure, only circadian swings. Labile hypotensive periods in early life may be followed by hypertensive in later years, just like early hypoglycemia swings may eventually result in diabetes.

Cortisol levels are maximum in the early hours of the morning and minimum at night. Cellular division in the adrenals is highest during daytime activity, lowest during sleep. Contrastingly, it is greatest in the liver and skin during sleep.

Halberg and Garcia-Sainz<sup>7</sup> investigated the rhythmicity of cancer cells. They found that malignant cells have eight to 20 hour mitotic cycles as contrasted to normal rhythms of 24 hours. Cancer cells, after x-ray therapy, were more circadian and their fast mitotic periods slowed down. Breast cancer cells, contrastingly, show a circadian rhythm, probably due to location or hormonal influences. In many cancer patients temperature rhythms are abnormal.

Kennedy noted a cyclic pattern in white cell and platelet levels in some cases of chronic myelogenous leukemia. During observations ranging from 30 to 50 days, white cell counts rose and fell cyclically from a high of 90,000 to a low of 4,000 even though hydroxyurea drug therapy was unchanged. Similar cycles were seen in leukemia patients getting no drug therapy, suggesting that the cellular rhythms are intrinsic.

When carcinogens were implanted in experimental animals, the first sign of malignancy was arrhythmic mitoses in the skin cells of the ear, long before the cancer became apparent. Abnormal temperature rhythms were also noted. These findings are, therefore, early warning signs of cancer.

Pizzarello<sup>8</sup> noted that a fixed dose of x-ray radiation that would kill mice at night, when they were active, only made them ill in their sleeping phase. This lethality may be due to the radiation striking the bone marrow and spleen when the cells were at the nadir of mitoses. Antimetabolite drugs may be most effective against cancer cells when they are at the peak of mitoses.

Animals are more susceptible to drugs<sup>9</sup> at certain times than at others. When injected with a large dose of alcohol, 60% of mice died at the

end of their rest period (8:00 p.m.), but only 12% died at the end of their active period. Maximum sensitivity to halothane occurred during the middle of the active phase, when the animal was least sensitive to other toxins.

Rats are most vulnerable<sup>10,11</sup> at the beginning of their active period to pentobarbital, acetylcholine, metyrapone, alcohol, and ouabain, while they are most susceptible during their active phase to chlordiazepoxide (Librium-R) and amphetamine. Succinylcholine is most lethal at the beginning of activity and the beginning of rest, when its detoxifying enzyme, liver esterase, is reaching its lowest circadian level. The rhythm of other detoxifying enzymes needs further study.

Our responses to drugs and toxins depend upon the circadian phases of our liver and kidney enzymes. Their rhythms are affected by light-darkness cycles, diet, coenzymes, and drugs like the barbituates, which alter DNA and RNA synthesis in the cells. These enzymes have peaks and troughs, but at different times, and there are even sex differences because male and female livers have slightly different time-phases.

Man's circadian rhythms can be thrown out of balance by jet travels to the East or West, not North or South, because they are in the same time zone. When four or more time zones are quickly passed in either easterly or westerly directions, our biologic time clocks are disturbed. We can make up our sleep loss quickly, but it takes a week or more for our clocks to be reset to the new time zone. In the interim, an individual is not at top efficiency.

Histamine reactivity<sup>12</sup> of the skin is highest at 11:00 p.m. and allergy skin tests done then show more marked whealing, while skin histamine reactions are lowest at 11:00 a.m. Antihistamines had a far greater impact when given in the morning than at night. The morning dose lasted 17 hours while the evening dose was ineffective after several hours.

Skin and liver mitoses are circadian, peaking during the night. Injury to the skin, however, induces a burst of local mitosis to heal the injury. Cutaneous activity increases during the summer. Whether this seasonal rhythm is mediated by light or temperature or both is not known. In any event the hair and nails grow more rapidly at this time.

The pituitary gland is cyclic in activity. One of its functions is to stimulate the adrenals and gonads to produce male sex hormone. Testoster-

one controls sex hairs in man and women. Facial hair in men is hormone dependent for growth, yet postmenopausal women often develop this hair even though lacking the hormone.

Unlike nail development which is continuous, hair growth is cyclic. A growth period is followed by a resting period. Nor is the cyclicity synchronized among the adjacent follicles. In fact each unit grows independently in its own phase. Hairs in various regions have different cycles. On the eyebrows, trunk, and extremities, growth period does not exceed six months, and the resting phase lasts for about the same period. On the scalp, hair grows for two to six years and even longer, and the resting period is probably a few months. Stress may interfere with hair growth and structure, especially in the scalp.

Melanocytes are neural in origin and invade the dermis in fetal life. They produce melanin for the keratinocytes. Melanin synthesis control is local, hormonal, and neurogenic. Local inflammatory episodes increase melanogenesis. The circadian pituitary produces MSH (melanocyte stimulating hormone) which darkens the skin. Corticosteroids inhibit MSH, and when they are deficient in Addison's disease the skin darkens. Melatonin, produced by the circadian pineal, lightens the skin. Obviously there is some synchrony among these endocrine glands in establishing a dynamic equilibrium in pigmentation.

In some brain disorders, the pituitary is thrown out of phase and produces more MSH to darken the skin. In anxiety and pregnancy MSH is also increased. A possible direct neurogenic regulation of pigmentation is hypothesized for melanocytes because they look like neurones, they come from the neural crest in fetal life, and experiments in fish and the cutaneous pigmentation in von Recklinhausen's disease tend to confirm this viewpoint.

Sebaceous glands enlarge at puberty indicating hormonal control. Large doses of androgens in animals produce enlargement and estrogens cause atrophy. Heat or testosterone accelerate sebum formation, while estrogens decelerate it. As the gonadal hormones are under pituitary guidance, circadian rhythmicity may play a role in this process.

Hellbrügge<sup>13</sup> noted a circadian rhythm in infants on a self-demand feeding. Electrical skin conductivity was highest during the morning and lowest at night. This phenomenon was the first circadian rhythm observed in the early weeks of



life. In the second and third weeks urine flow was highest in the daytime. Between five to nine months temperature, blood sugar, urine flow and urinary constituents became circadian. Cardiac circadian rhythm was established between one to five months.

Scheving and Pauly<sup>14</sup> demonstrated that strong circadian rhythms exist in cells which renew themselves rapidly such as skin, hair, eyes, ears, and tongue. For they are constantly being subjected to trauma and wear and therefore need quick restoration. Human adult cutaneous cells renew mostly between midnight and 4:00 a.m. and the rate of growth is in equilibrium with loss. Scheving and Pauly showed that rat corneal mitoses were not affected by removal of the pituitary or adrenals.

Reimann<sup>15</sup> suggests that certain periodic diseases may be due to sudden hyperactivity of the hypothalamus. This phenomenon occasionally causes changes in the numbers of certain blood cells, edema of the skin and other tissues, recurrent fever, migraine, and psychotic flareups. Purpura (blood platelets have a life cycle of seven days) of the skin and internal organs may be linked to periodic edema and may possess a neurovascular cycle. Reimann also cites cases of periodic hypertension.

Cox<sup>16</sup> says that cellular proliferation in psoriasis is a fluctuating process subjected to some mechanism of control that restricts mitosis and restores a normal zone of cornification. Treatment should be given with these fluctuations in mind, striking the rapidly growing cells at their vulnerable phase.

Frost<sup>17</sup> and Weinstein,<sup>18</sup> using tritium-labeled thymidine, found that psoriatic mitosis-cycles were 37.5 hours, 12 times the normal rate of epidermal cell replication. Consequently, they give methotrexate orally at 12 hour intervals for 36 hours and repeat the dosage schedule weekly until remission occurs.

What the relationship may be between cyclicity and cutaneous diseases such as contact dermatitis, atopic dermatitis, and chronic urticaria has not been investigated. Is the skin more vulnerable at certain times to contact irritation or contact sensitization, urticaria, and neurodermatitic responses? For atopic diseases flare in the spring and fall; it also seems logical to expect the skin to be more resistant to infections at certain hours and more susceptible at others.

Tests with monkeys<sup>19</sup> demonstrated that emotional stress would shift the brain temperature

rhythm 15 to 30 minutes a day. Coincidentally, the monkeys developed skin sores, skin ulcers, bleeding stools, asthmatic breathing, neurotic or psychotic behavior. Researchers speculate that emotional or infectious stress may occur in a person at a critical asynchronous phase in time, knocking these rhythms into an abnormal period of synchrony.

The pineal gland<sup>20</sup> is an organ that keeps the neuroendocrine system informed about light and dark alternations. With the exception of birds, where photostimulation is received directly through the skull, all other animals receive it indirectly by their pineal glands.

When activated by light, pineal noradrenaline changes pineal serotonin to pineal melatonin, the hormone which lightens the skin. Pineal melatonin also affects the gonads, brain wave tracings, and induces sleep.

Pineal noradrenaline, serotonin, and melatonin all have circadian rhythms. Pineal noradrenaline drives the pineal rhythms of the other two. Noradrenaline levels are three times higher at 7:00 a.m. than at 7:00 p.m. in the rat. Constant light or darkness stops the rhythm.

The pineal gland obviously relays data concerning daily light wave cycles, color information, and artificial light sources. Changes in daily light reception by the brain may be responsible for seasonal changes seen in humans which produce spring fever, ulcers, psychoses, and suicides.

Investigators have examined the body looking for the origin of the circadian rhythm. Tissues have been removed, but their circadian cyclicity still remains. Organs have been removed but still the body is rhythmic. Animals have been blinded, kept in constant darkness or constant light, but their cycles have only been altered slightly. The conclusions from all these experiments is that circadian periodicity is constant, and that various systems may have their own independent rhythms.

Scientists have been looking for the hypothetical master clock which controls all circadian rhythms. None has been found as yet. Wurtman and Axlerod<sup>21</sup> believe there should be one, and it must be in the central nervous system. Hastings<sup>22</sup> feels the synchronizing timepiece is somewhere in the organism and subject to geophysical influences.

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References are available from the author upon request.

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# Spontaneous Leg Cramps and "Restless Legs" Due to Diabetogenic (Functional) Hyperinsulinism

## A Basis For Rational Therapy

H. J. ROBERTS, M.D.

The proper use of hypothesis . . . must bring together scattered data or explain a previously unexplained phenomenon.

M. D. Altschule  
(Med. Sc. 17:94, 1966)

**Abstract:** Reactive hypoglycemia due to diabetogenic (functional) hyperinsulinism has been the most frequent definable cause of severe spontaneous leg cramps and "restless legs" encountered in more than 350 patients presenting with these features. Indeed, they should be regarded as possible clues to the existence of a diabetic diathesis. Such perspectives provide a rational and practical basis for the management and prevention not only of these complaints, but also of associated cardiac and neurologic disorders—especially nocturnal angina pectoris.

The physician is frequently confronted with the problem of spontaneous leg cramps (SLC) (systemma) and related muscular spasms that have resisted treatment. The same consideration applies to so-called restless legs (RL) ("fidgety legs," "leg jitters," "nervous legs"). These are involuntary movements of the lower extremities, often accompanied by numbness or paresthesias. The shortcomings of both the diverse etiologies and treatments suggested for these disorders are recognized by most clinicians. I do not believe that varicosities, previous thrombophlebitis, atherosclerotic changes in large or small peripheral vessels, prolonged dependency of the limbs, or engorgement of the venous system within the spinal canal can be invoked as primary causes in most instances of SLC and RL. Admittedly, they may serve as contributory or aggravating factors.

### Clinical Observations

On the basis of a consultation experience that now encompasses more than 350 patients in whom severe SLC or RL were presenting or prominent complaints, the most consistent definable etiology I have encountered has been reactive hypoglycemia due to diabetogenic (functional) hyperinsulinism, with or without decreased glucose tolerance.<sup>1-4</sup> Approximately two thirds of these patients had SLC alone, while one third experienced both SLC and RL. Although the calf and foot musculature usually was involved, an occasional patient suffered cyclic cramps primarily in such areas as the upper thigh, low back, or hands. Several instances of severe nocturnal carpal spasm and the "stiff-man syndrome" also were encountered.

The following observations serve to underscore the frequent etiologic role of the diabetogenic hyperinsulinized state in these disorders.

1. With few exceptions, these patients also experienced the typical features of recurrent hypoglycemia. They included recurrent intense hunger, episodic weakness, profuse sweats, tremor, palpitation, and various neuropsychiatric complaints several hours after a previous meal, with prompt amelioration by the ingestion of food or something sweet.

2. Reactive hypoglycemia was confirmed by glucose tolerance testing. Conventional morning testing may fail to document the presence of diabetogenic hyperinsulinism owing to the cyclic acceleration of insulinogenesis as the day advances. In such instances, its presence usually could be convincingly demonstrated by the method of afternoon glucose tolerance testing.<sup>5,6</sup>

From the Mannow Research Laboratory, Palm Beach Institute for Medical Research, West Palm Beach. Dr. Roberts is director of the Institute.

3. An attack of muscle cramps occasionally was precipitated concomitantly with an hypoglycemic attack during the course of glucose tolerance testing.

4. A prompt and persistent remission or striking alleviation of longstanding SLC and RL followed institution of a corrective diet aimed at preventing severe hypoglycemia day and night in the vast majority of these patients, notwithstanding the previous ineffectiveness of a variety of drugs, vitamins and physical maneuvers.

5. Similarly, recurrence of SLC usually could be directly attributed to some dietary indiscretion within the preceding 12 hours capable of precipitating an hypoglycemic attack—notably, the ingestion of sugar (often in an unrecognized form) or alcohol, and prolonged abstinence from food. Excessive activity occasionally played a contributory role. (It is recalled that carbohydrate is the chief source of energy for muscular work).<sup>7</sup>

#### Related Observations

The following clinical and investigational findings in these patients, detailed elsewhere,<sup>1-4</sup> also are pertinent.

1. The frequency of associated cyclic spasms in other muscle groups—viz., nocturnal angina pectoris, priapism and nocturnal diarrhea. In a sense, hypoxia is a common denominator with reference to both the muscular glucopenia (metabolic hypoxia) causing SLC or nocturnal angina pectoris,<sup>8,9</sup> and the metabolic-ischemic hypoxia underlying angina of effort or intermittent claudication in occlusive peripheral vascular disease.

2. The high incidence of other nervous system complications including dysrhythmias, narcolepsy and peripheral neuropathy, presumably representing additional neurologic sequelae of longstanding recurrent hypoglycemia.

3. The presence of diabetogenic hyperglycemia or decreased glucose tolerance in approximately two thirds of these individuals. Such diabetic responses often were demonstrable *only* by the method of afternoon testing because of their circadian “high-output failure” of insulinogenesis.<sup>5,6</sup>

4. Increased serum insulin and sodium, decreased sodium potassium and calcium, and water retention following the ingestion of a standard glucose load—each contributing to altered neuromuscular function.

5. The oft-dramatic increase of insulin release in the late evening and early morning hours re-

ported by Lambert and Hoet<sup>10</sup> during 24-hour sampling, even among controls.

6. The striking exaggeration of insulinogenesis during pregnancy or after administration of birth control preparations in small doses (as sequential or combination therapy) for three months.<sup>11</sup> This factor probably accounts as much for the aggravation of SLC during gestation as does calcium deficiency or local pressure onto the pelvis.

#### Treatment

Corrective dietotherapy centers about a regimen that is relatively high in protein, adequate in fat, and devoid of added sugar or food containing considerable simple sugars. Common dietary offenders in the latter category include pineapple, apple, melon, banana, mango, citrus fruits and their juices, raisins, corn flakes, dried fruit, chewing gum, soft drinks, regular bread, and most commercial soups.

Such patients also must resort to “scientific nibbling” on a 24-hour basis if severe reactive hypoglycemia is to be avoided. This necessitates at least one feeding during the night. Since many of these individuals fail to perceive nocturnal hypoglycemic attacks, it is mandatory that they be awakened—even by the spouse or an alarm clock—if more serious muscular, neurologic and cardiac complications of diabetogenic hyperinsulinism are to be averted.

Other precautions include the following:

1. Curtailment of excessive smoking, owing to its documented aggravation of reactive hypoglycemia.<sup>12</sup>

2. Abstinence from alcohol, which often predictably precipitates or aggravates hypoglycemia in these persons.<sup>13</sup>

3. The limitation of caffeine, a drug known to potentiate muscular contraction and aggravate the diabetic-hyperinsulinized state.<sup>14</sup>

4. Avoidance of excessive fluid intake, since overhydration tends to compound the metabolic insult of tissue glucopenia.<sup>4</sup>

Various adjuvant drugs merit trial in selected patients when the aforementioned measures are not completely successful.

1. Diphenylhydantoin (Dilantin) occasionally has proved of considerable value, presumably because of its action on neuromuscular synapses, the reduction of sodium flux into muscle and nerve cells, and an inhibition of insulin secretion.<sup>15</sup>



2. Mild sedation, calcium, potassium chloride, and diphenylhydramine (Benadryl) have benefited individual patients. The use of "peripheral vasodilating" drugs has infrequently been indicated or effective.

3. Phenformin (DBI-TD) has afforded symptomatic benefit of SLC and improved diabetogenic hyperinsulinism in many patients having "early chemical diabetes" (i.e., decreased glucose tolerance demonstrable only by afternoon glucose tolerance testing).<sup>16</sup> It reduces excessive insulin output<sup>17</sup> and increases glucose utilization in muscle.<sup>18</sup> The dosage is generally 50 mg. daily.

4. Vitamin E has been recommended by others for these disorders, preferably in a water-solubilized form (Aquasol E), the dosage ranging from 100 to 400 international units three times daily before meals.<sup>19</sup> Although the response has varied, striking remissions appear to have been achieved in selected patients.

5. Other vitamins appear to have been beneficial in some instances of severe SLC and RL. They included oral niacinamide, pyridoxine and ascorbic acid, and parenteral vitamin B<sub>12</sub>.

6. Nandrolone phenpropionate (Durabolin) has provided consistent benefit for an associated severe diabetic-type neuropathy.<sup>1-4, 20</sup>

7. Adrenal cortex extract may provide symptomatic benefit in some patients of the chronic fatigue and other symptoms (e.g., severe sweats, associated with chronic reactive hypoglycemia.) I have not been impressed by its need or efficacy, however, in the management of SLC and RL when the basic aspects of dietary management were instituted.

Ancillary physical measures might reduce neuromuscular irritability in the lower extremities. They include (1) the avoidance of habitual leg crossing,<sup>21</sup> garters and tight panty girdles; (2) the wearing of elastic stockings or bandages aimed at minimizing venous stasis or postural hypotension, when present; (3) intermittent periods of recumbency during the day, and (4) the wearing of sensible foot wear (i.e., avoiding excessively narrow shoes and high thin heels).

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Sympathy is for the one who tried and failed; pity is for the one who failed to try.



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\*Koch-Weser, J., et al.: Arch. Intern. Med., 128:399, 1971.

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# Diabetic Children's Camps Announced for June 17-30

Florida's Camp for Children and Youth with Diabetes, begun in 1962, was incorporated not-for-profit in 1970. The directors include physicians, nurses and non-medical leaders in diabetes activities. Medical and nursing direction comes from the University of Miami and Mt. Sinai Hospital of Miami (Drs. Patricia Conly and Milton Grossman), the University of South Florida (Dr. John Malone) and the University of Florida (Barbara Sepcie, R.N., and Dr. Arlan L. Rosenbloom).

Administrative support is provided by the National Foundation—March of Dimes through the Birth Defects Center at the University of Florida.

Children's camp (ages 7-12) will be held at YMCA Camp McConnell near Micanopy, 10 miles south of Gainesville on Highway 441, from June 17-30. One hundred to 120 youngsters are expected to attend. The YMCA program includes vigorous sports (rowing, swimming, horseback riding, canoeing, hiking, sailing, golf, trampoline, dancing) as well as quiet activities (crafts, archery, nature lore, music).

The Youth Program (ages 13-20) will be held on the University of Florida campus during the same two-week period. Eighty to 100 are expected to participate. The campers will live in comfortable

dormitories on the UF campus, within a short distance of many sports and cultural activities, including archery, tennis, crafts, hiking, swimming, acrobatics, basketball, softball, volleyball, golf, the Florida museum and galleries and the Reitz Union theatres and galleries. Excursions to Disney World and a tubing trip are planned.

Camp fee is \$175. This cost is based on the YMCA charge for children or the room and board costs on campus plus the costs of staff. All medical supplies are donated and no salaries are paid to professional staff.

Since fewer than half the youngsters can afford the camp fee, and ability to pay is not requisite for enrollment, additional assistance is essential. The camp fees are paid for many by United Way (Orange and Alachua Counties), CHAMPUS, Bureau of Crippled Children, Vocational Rehabilitation, affiliate chapters of the Florida Diabetes Association, the Juvenile Diabetes Foundation (Miami) and numerous civic clubs, individual and corporate donors. A number of Florida physicians solicit donations from adult patients with diabetes.

For additional information or applications, contact one of the Medical Directors or Mrs. Wilma Van Der Beek, Executive Secretary, 1910 Riverside Drive East, Bradenton, Florida 33505 (Telephone: (813) 746-7071).

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## A Malpractice Threat From Whole Blood Transfusion

The whole is riskier than the sum of its parts, warns hematologist Peter V. Van Schoonhoven—when the whole is blood. Malpractice lawyers may soon begin to zero in on whole-blood transfusions in which a blood component could have been substituted, he says. One threat he cites: the mounting evidence that packed red cells offer less risk of serum hepatitis than whole blood.



# Pediatric Congress Report and Other Thoughts

The scientific program of the Xth Pan American Congress of Pediatrics in Cordoba was excellent. There were 190 papers presented by physicians from Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Paraguay, Peru, Puerto Rico, Sweden, Venezuela, United States and Uruguay.

By comparison each session of the XIIIth International Congress of Pediatrics in Vienna seemed to suffer from a dearth of thoughtfully selected papers. An occasional worthwhile contribution was engulfed by others which should never have had a place on the program.

The papers at Cordoba fell roughly into two groups. There were those which dealt with poverty, malnutrition, diarrhea, parasitic infestations, infectious diseases and high infant mortality rates; in short, acute problems in developing countries. These presentations seemed to contain something of a cry for help and I found myself moved by a realization that here was a purpose for international cooperation. If there is such a thing—and unfortunately I know there is—as national pride coupled with jealousy and international animosity, then it should be noted that such feelings were either completely suppressed or entirely absent in a gathering of physicians dedicated to the welfare, health and happiness of young children regardless of color, creed or country.

The second group of papers dealt essentially with scientific areas of pediatrics in which there has been much recent progress. For the most part—but not exclusively—these reviews were presented by physicians of pediatric eminence in the United States.

Aware of the possible financial problems, I was interested in ascertaining where the money came from to make the Congress possible. Those with something to sell carried the major burden.

Most of all I was impressed by activities of the American Academy of Pediatrics. Acting on advice of an organized committee, six prominent American pediatricians were invited to submit two papers each in the field of their eminence. Expenses were provided by NIH grants. One of these was Dr. Richard T. Smith of Gainesville.

Apart from events of the Congress, severe malnutrition was observed among the Indians of Guatemala. To an appreciable extent, its effects were apparent in the market places of Chichicastenango but the most severe examples were seen in the hospital at Guatemala City and its outpatient division. Not since teaching pediatrics in Peking, China in 1928-1930 have I witnessed such evidence of utter starvation. Many who rant about malnutrition in the United States have no concept of the tragic plight of the truly starved child.

Face pinched with mild edema about the eyes, arms reduced to broomstick size with loose skin as evidence of progressive weight loss, clavicles and scapulae prominent with ribs outlined on the wall of the thorax—all these signs of wasting masked by edema of the lower half of the body. Closer observation reveals desquamation of pigmented skin, round punched-out ulcers of the legs, cachectic purpura, corneal ulcers, and magenta-colored tongues.

War, hunger and famine—names that catalog human adversity—more accurately describe the state of these Guatemalan children.

Surely food, medicine and education are needed but without control of breeding these measures are doomed to fail. Nearly everyone past age seven or eight has a baby strapped to his back. These people are Christians and only through the Church can they be taught what is needed for physical and mental salvation. They are fertile, prolific, but there is no gonorrhea or syphilis among them. They are not promiscuous.

This report has been an excuse to unburden the ache of a soul; perhaps its message will attract those in organized medicine concerned with responsibility for the health and happiness of people wherever they are.

A. ASHLEY WEECH, M.D.  
GAINESVILLE

Editor's Note: Dr. Weech, retired Chairman of the Department of Pediatrics of the University of Cincinnati College of Medicine and formerly Chief Editor of the American Journal of Diseases of Children, has become an active member of the Department of Pediatrics at the University of Florida College of Medicine. In late 1972 he traveled in Central and South America with the assignment of representing the American Medical Association at the Xth Pan American Congress of Pediatrics in Cordoba, Argentina. This article is excerpted from his report to the AMA.

# RX For Prandial Pleasures

RICHARD AND LENORE FLEMING

*Editor's Note: Again this year, Dr. and Mrs. Fleming researched "good eating places" in the area of the annual meeting in order to make your visit to Bal Harbour more enjoyable.*

Just as no prescription is universally applicable to all patients, no recommendation for food would appeal to all palates. You might have your own favorites—if not, here's an abbreviated gastronomic pharmacopeia of the lower Gold Coast which you might find helpful in choosing a place to dine.

We have rated the various restaurants according to charges as follows: Inexpensive—\$6.00 or less. Moderate—\$8.50 or less. Expensive—\$8.50 to \$11.00. Very expensive—over \$12.00. These prices do not include wine, dessert, taxes and tips. With the devalued dollar, these figures may be off by May but they should serve as a relative guide.

## Bal Harbour—Bay Harbor

**Gauche Room, Americana Hotel:** The Americana is well prepared to feed you well! Check the hotel directory. The Gauche Room is everybody's favorite and if you haven't eaten there before, you certainly should. The steaks are great as are the other meats. Moderate.

**De Continental:** 1045-95th Street. 865-8224. French-Italian dishes. Elegant setting. Expensive to very expensive.

**Post & Paddock:** 9650 E. Bay Harbor Drive, Bay Harbor Island. 866-8706. American cuisine; steaks, seafood. Old standby. Small version of 21 Club in New York. Moderate—Expensive.

**Cafe Chauveron:** 9561 E. Bay Harbor Drive, Bay Harbor Island. 866-8779. The most recent addition to the area's constellation of great restaurants. This well known New York restaurant moved into the old Tony Sweet's location, refurbished it completely to make it one of the most elegant, plush and expensive places here. Chiefly French cuisine; excellent. Very expensive.

## Hallandale and Upper Miami Beach

**Manero's Restaurant:** 2600 East Beach Blvd. 923-1661. Steaks and Italian food; known for cheese salad. Very popular; usually overflowing. Moderate.

**Wan's Mandarin House:** 2200 N.E. 163 Street, No. Miami Beach. 947-4536.

The original Wans on S.W. 8th Street in Miami has been our favorite local Chinese restaurant for a number of years. Delicious dishes whet even the most jaded appetite! Ask for the specialties. Two of ours: Dragon and Phoenix, Double Happy with sizzling rice. Inexpensive—Moderate.

**Grist Mill:** 19400 Collins Avenue. 947-2676. In the Sheraton Beach Resort Hotel on the ocean. And it is a grist mill—an attractive replica, that is! American cuisine; large menu. Everybody seems to enjoy this one. Moderate.

**Christine Lee's Gas Light Restaurant:** 17901 Collins Avenue. 945-9075. Excellent Chinese food and American too, especially the steak—none better. Moderate.

**The Red Coach Grill:** 18050 Collins Avenue. 949-5461. This is a welcome addition in this area. There are two other locations: In Miami, 1455 Biscayne Boulevard—379-4008. In Ft. Lauderdale 1200 No. Federal Highway. 1-564-0432. Consistently good food. Large squares of butter and delicious breads their trademark. Caesar's salad at no extra charge is delicious. Maine lobsters when available are the best we've ever had. Inexpensive—Moderate.

## Miami Beach

**Bernard's:** 5401 Collins Avenue, in the Carriage House Apt. Hotel. 864-4804. Small, plush, quiet. Continental cuisine. Menu limited but excellent and especially prepared by Bernard. Very expensive.

**Embers:** 245 - 22nd Street. 538-4345. Famous for hickory cooked steaks, ribs and chops as well as pheasant and other fowl. Always popular. Moderate—Expensive.

**Gatti's:** 1427 West Avenue. 637-1717. One of the oldest and best restaurants on Miami Beach. Italian with continental flair. Veal dishes outstanding. Joe Gatti will charm you. May be closed; be sure to call. Moderate—Expensive.



**Joe's Stone Crabs:** 227 Biscayne Street (near the southern tip of Miami Beach). 637-0365. A landmark. No one wants to miss this one—marvelous stone crabs (cold of course), hot drawn butter, hash-brown potatoes and the secret formula coleslaw washed down with Heineken's beer. No reservations and you will wait (pleasantly, in the bar!) unless you come before 6:30 or after 8:45. Moderate—Expensive.

**Le Parisien:** 474 Arthur Godfrey Road (41st St.). 534-2770. Small, chic, French cuisine of highest quality. Try Duck a L'Orange if you like duck. Expensive.

**Old Forge:** 432 Arthur Godfrey Road. 534-4536. Site of old blacksmith shop in the days when there was a polo field up the street off Arthur Godfrey Road. We used to enjoy dining in the open patio around the tree where originally the horses were shod and where later St. Gaudens, the sculptor, had his studio upstairs. But alas, progress has pulled the tree down and converted the patio to another room. Interesting decor however. Wander through the old fashioned bar for a look at the art but get a table for dining as far away as possible or you'll be blasted out of your seat when the rock band starts! Excellent steaks and chops. Usually crowded but the service is good. Open late. Moderate—Expensive.

**Omar's Tent:** 534 Arthur Godfrey Road. 532-8422. Small and unpretentious place with variety of excellent Syrian-Lebanese foods. The Kibbi Tartare and Tabooley salad are excellent side dishes but can be a meal in itself. Desserts are mouth-watering. The Turkish coffee is "mud" but we like it. Inexpensive—Moderate.

#### 79th Street Causeway—Miami Beach

**Nick & Arthur's:** 1601-79th St. Causeway. 866-9759. Excellent food; American cuisine; steaks, stone crabs. Large and somewhat bustling. Good service. Moderate—Expensive.

**Mike Gordon's:** 79th St. Causeway on the Bay at Miami side. 759-6825. Old reliable seafood place; Red Snapper a specialty. Moderate.

#### North Miami—Off Broad Causeway

**Cattleman:** 1800 N.E. 124 Street, Miami. 891-1600. Plush 1890's decor with 5 or 6 rooms decorated differently—be sure to see them all. Good food—American. Complimentary wine, liqueurs and cigars with steaks. What more can

one ask? Although crowded and somewhat commercialized, it's worth a visit for the atmosphere. Moderate.

**Casa Santina:** 10999 Biscayne Blvd., Miami. 754-2431. Real Italian—none better. Very popular. Moderate—Expensive.

#### Miami

**Prince Hamiet Danish Restaurant:** 8301 Biscayne Blvd. 757-5541. An outstanding restaurant with that wonderful Copenhagen charm and decor. Tables, chairs, baby carriages, etc. suspended upside down from the ceiling—the pixyish Danish sense of humor—rough hewn interior, costumed waiters and a friendly atmosphere so typical of Denmark. The complimentary seafood bar has everything imaginable including caviar and one must be careful not to make a meal of it here for the best is yet to come. Bouillabaisse, fish, steaks—all tastefully prepared and oh yes—be sure to go Danish all the way by downing a thimbleful of aquavit (is permitted to chase with beer p.r.n.). Skoal!! Always crowded—even with reservations there is a wait unless you come early but it's worth it. Moderate.

**Chez-Leon:** 128 N.E. 17th St. 374-8825. A typical provincial type French restaurant on the first floor of a two story home hidden in the middle of the automobile district. You'll never find it—ask us! Papa Leon has "mastered the art of French cooking" and his offerings are excellent. Madame Leon runs the rest of the establishment with Gallic charm and efficiency and you can depend on her suggestions. The sweetbreads, frog legs Provencale, trout Meuniere are noteworthy. Inexpensive—Moderate.

**Cafe Les Ambassadeurs:** In the Sheraton Four Ambassadors: 801 S. Bayshore Drive. 377-1966. French cuisine. Elegant dining in a plush setting. Strolling violins; steaks flamed at table. Steak au Poivre great if your stomach mucosa is in reasonably good condition. Crepe Suzettes and Cafe Don Juan prepared by the Maitre d' with a flourish. Moderate—Expensive.

**Piccadilly Hearth Restaurant:** 35 N.E. 40th Street. 751-1818. Located in the midst of Decorator's Row. (The ladies in particular will enjoy strolling thru this unusual street). Small, charming, elegant English Pub decor. Delicious food with daily specialties; equally good for lunch. Veal dishes outstanding. Moderate.



**Vizcaya Restaurant:** (No connection with Vizcaya Art Museum). 2436 S. W. 8th Street. 642-9022. Spanish-Basque cuisine. Large selection; delicious; crowded and lively. Flamboyant decor. Moderate.

**Centro Vasco:** 2235 S. W. 8th Street. 643-9606. Like the Vizcaya; Spanish-Basque. Seafood, steak madrilene a specialty. Can't go wrong with either of these. Moderate.

**Les Violins, Inc:** 1751 Biscayne Blvd. 371-8668. Operated by group of Cuban expatriates, all of whom work as waiters, cooks, managers, etc. The waiters double as entertainers (they're good too!) Moderate.

**Flamenco Supper Club:** 991 N.E. 79th Street. 751-8631. Same as above with same operators.

#### Coral Gables

**Chez Vendome:** 700 Biltmore Way, Coral Gables. 443-4646. An intimate version of the Cafe des Ambassadeurs. French cuisine equally as good and served with the same flair. Moderate—Expensive.

#### Miami Springs

**Japanese Steak House:** 500 Deer Run. 871-6000. Pretty girls in kimonos prepare your beautiful steak Japanese style where you sit; either at a floor table or conventional table. A tasty treat and delightful experience. The homeopathic servings of Sake are just right. One price: \$8.50.

**King Arthur's Court:** 500 Deer Run. 871-6000. Huge, high-ceilinged room with ornate Medieval decor attractively done. You guessed it—Beef is the favorite and the prime ribs are the best. No reservations—usually a wait, especially on week-ends. Moderate—expensive.

#### Key Biscayne

**Jamaica Inn Restaurant:** 320 Crandon Blvd. 361-5481. Spacious, with enclosed tropical garden. American cuisine; Roast Beef a specialty; frog legs, steak, etc. Moderate—Expensive.

**The English Pub:** Next door to Jamaica Inn. 361-5481. Copy of an English Pub and most attractive. Informal. Be sure to look at the various rooms. Menu similar to above. Moderate.

#### Ft. Lauderdale

**Down Under:** 3000 East Oakland Blvd. 564-6984. Attractive and unusual decor, located literally "down under a bridge" on the intercoastal

waterway. Large variety of delicious food tastefully prepared and interestingly served. Moderate.

**Le Dome of the Four Seasons:** 333 Sunset Drive. 525-3303. Continental cuisine; excellent. Magnificent view worth visiting for this alone! Expensive.

**Clipper Room at Yankee Clipper:** 1140 Seabreeze Blvd. A1A. 524-5551. Excellent continental cuisine; intimate, charming. Moderate—Expensive.

**Benihana of Tokyo; Japanese Steak House:** 4343 Trade Winds Ave., Lauderdale by the Sea. 566-1569. Beautiful Japanese style architecture and landscaping on the inland waterway. The steaks and vegetables are cooked on a hibachi surrounded on three sides by a table while the chef on the fourth side performs magic with his knife as he slices and flips the steak. The meat is marvelous—said to be Kobe (Japan) beef—from cattle pampered on beer. Two slight faults—unless you come with a party of 8 you'll share a table with strangers since all tables are for 8 and the place is always busy. Secondly, I detected on one visit a sense of "super-efficiency" which borders on commercialism. For instance, before we were finished eating, the chef had cleaned the hibachi and brought in a new stack of dishes—a gesture I missed on the first round! Despite this, we recommend that you try it for you will certainly like the food.

Visit the Tempura Bar in the "basement"—delicious fish prepared Japanese style. You might try this for appetizers or if you're not ravenously hungry, make a meal of it here. We have been told that they are planning to build another place on the 79th St. Causeway in Miami Beach. You might check and see if they have opened before taking the longer trip to Lauderdale. Moderate.

Be sure to call for reservations—most places require it (two or three exceptions). Although we have checked most of them as to closing dates for the season, this sometimes changes and you might save a trip by making a call. Get a map and directions before setting out—it will save you time!

SIG: Take one each night ad lib.  
Repetatur p.r.n.

► Dr. and Mrs. Fleming, 1688 Meridian Avenue, Miami Beach, Fla. 33139.

Reprints will be available at the Registration Desk in the Americana during the annual meeting.

# Use of Blood Components

E. O. Carr

**Abstract:** Since the advent of plastic equipment for collecting blood, it has become relatively simple to supply specific blood components for patient needs. Infusing only the blood product in which the recipient is deficient has allowed the blood banks to "stretch" their blood donations by transfusing up to four or five patients from one donor—thereby conserving a vital human resource.

## Packed Red Cells

Red blood cells prepared in a closed system by removing enough plasma to affect a hematocrit of 60-70% have the same in-date period as whole blood. Therapeutic advantages of red cells over whole blood include: almost half the total volume with the same red cell mass, less sodium, acid, potassium, ammonia and citrate; minimal amounts of plasma antigens and antibodies. Group O red cells have an additional advantage in that they can be used with relative safety in emergency situations when group specific blood is unavailable. It has been shown that 80% of transfusions can be given as red cells.<sup>1</sup>

## Leukocyte Poor Red Cells

In over 60% of febrile transfusion reactions, leukoagglutinins have been demonstrated.<sup>2</sup> Clinical symptoms produced by this particular antigen-antibody reaction may include: flushing, palpitation, increased pulse rate, cough, chill, elevated temperature, rise in diastolic blood pressure, headache, malaise and occasionally nausea and vomiting. Due to the unavailability of reagents, it is impractical to try to select leukocyte compatible blood for routine transfusions. However, there are several methods available for effective removal of leukocytes or reducing the number in the donor's blood sufficiently to permit

transfusion without untoward reaction. Two methods are simple and can be done in any blood bank. One consists of inverted centrifugation and transferring approximately 80% of the red cell mass into a transfer bag, leaving the buffy coat and the top layer of red cells which will contain the majority of leukocytes present. A disadvantage of this method is the loss of 20-25% of the red cells. The other method consists of passing blood through a column containing nylon fibers. To accomplish this latter procedure the blood must be collected in heparin and filtered within one hour from the time of bleeding. Another disadvantage is that it will only remove granulocytes.

An additional indication for leukocyte poor blood is the prospective transplant patient. Both lymphocytes and granulocytes carry histocompatibility antigens which may sensitize the recipient and jeopardize survival of the transplant; therefore, any blood transfusion should be as free of leukocytes as possible.

## Platelets

The clinical effect of platelet transfusions is transient. This fact, coupled with the risk of stimulating platelet antibodies with the possibility of rendering subsequent platelet transfusions ineffective, should discourage the transfusion of platelets without justifiable indications. When platelet counts are below 10,000 per cubic millimeter of blood, the risk of hemorrhage is great.<sup>3</sup> Three sources of platelets are available: fresh whole blood or packed cells, platelet rich plasma, and

Mr. Carr is Director of Technical Services, Central Florida Blood Banks, Inc., Orlando.



platelet concentrate. Platelet concentrate is usually the treatment of choice because virtually unlimited numbers can be transfused without fear of circulatory overload. The number of units of platelets to be given is governed by the body surface area and the clinical status of the patient. Roughly 90% of the platelets from one unit of whole blood will be recovered in platelet rich plasma (approximate volume 220 ml.) and 70-80% in platelet concentrate (volume 25 ml.). One unit of platelets from a donor with a platelet count of 250,000 per cubic millimeter will raise the one-hour post transfusion platelet count in a patient with one square meter of body surface 12,000-15,000 per cubic millimeter. This increase may not occur in patients with active bleeding, fever, sepsis, platelet antibodies and splenomegaly.

Platelet transfusions are indicated in cases of acute leukemia to affect both hemostasis and prophylactically, thrombocytopenia due to platelet loss from massive transfusions of stored blood, hypersplenism and in the preoperative preparation of patients with platelet counts of less than 100,000 per cubic millimeter. In surgical patients the platelets should be given in the operating room just prior to surgery. Other disorders, such as aplastic anemia, thrombocytopenia due to increased platelet destruction (drug induced), and qualitative platelet defects, should receive platelet transfusions only for life threatening bleeding episodes.<sup>4</sup>

#### Fresh or Fresh Frozen Plasma

Plasma separated from donor cells within four hours from time of bleeding and frozen or transfused within six hours from time of bleeding contains all coagulation factors except platelets. Fresh or fresh frozen plasma is most frequently used for patients with hepatic dysfunction or in bleeding episodes where the exact factor deficiency has not been pinpointed.

#### Factor VIII Rich Cryoprecipitates

Cryoprecipitate is the protein fraction recovered from frozen plasma by thawing slowly

at 4 C. This precipitated material is recovered by centrifugation and contains approximately 56% of the original factor VIII globulin in less than 3% of the plasma protein.<sup>5</sup> The concentrated material can be stored frozen for one year.

Cryoprecipitate is used primarily for the treatment of classical hemophilia patients but may be appropriate for patients with von Willebrand's Disease. Each bag contains about 130 units of antihemophilia globulin in a total volume of less than 5 ml. A unit is defined as the amount of AHG that will raise the AHG activity of 100 ml. of plasma 1% or that activity of AHG in 1 ml. of normal fresh plasma. A recommended dosage schedule is one bag of cryoprecipitate per 6 kg. body weight as the priming dose and one half this amount every 12 hours for maintenance. Infusion should be completed within three hours of thawing. Never infuse only one bag; since the individual bags are not assayed the AHG activity may vary greatly from bag to bag depending on donor and technique of preparation. For the treatment of classical hemophilia, cryoprecipitates are as effective as the commercial AHG concentrates and should be less expensive to the patient.

#### Conclusion

It is the responsibility of the blood bank to provide a constant supply of blood and blood components. However, since components have to be separated from the whole blood within four hours from the time the donor is bled and some have a very short in-date period, to assure maximum patient benefit the physician is urged to work closely with the blood bank.

#### References

1. Chaplin, H. Jr.: Use of Packed Red Cells, *New England J. M.* 281:367, 1969.
  2. Payne, R., and M. R. Rolfs: Further Observation on Leukoagglutinin Transfusion Reactions, *Am. J. Med.* 29:449, 1960.
  3. AABB Manual of Blood Component Therapy Preparation, Platelet Preparation, Chicago, 20th Century Press, 1969.
  4. Becker, G. A., and R. H. Aster: Platelet Transfusion Therapy, *Med. Clinics North America*, 56 (1) (Jan.), 1972.
  5. ABB Manual of Blood Component Preparation, Plasma Preparation, Chicago, 20th Century Press, 1969.
- Mr. Carr, Central Florida Blood Banks, Inc., 1300 South Kuhl Avenue, Orlando 32806.

## Peer Review Will Empty More Hospital Beds

The A.H.A. House of Delegates expects average hospital stays to shrink by two days over the next couple of years, spurred by peer review activities of foundations and P.S.R.O.s. Thus, it warns, unless hospitals can cut their bed capacities fast, occupancy rates will fall still further from the present national average of 76%.



# Encounter under the Scanning Electron Microscope



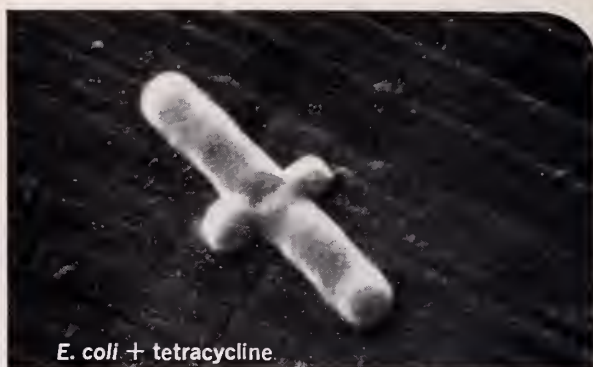
## SEM reveals changes in *E. coli* exposed to antibacterial agents

The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in

detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.



*E. coli* + sulfamethoxazole



*E. coli* + tetracycline



*E. coli* + cephalothin



*E. coli* + ampicillin

## Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,<sup>1-3</sup> strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of

its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

It should be noted that no clinical conclusions can be drawn from this study, as it is not always possible to extrapolate *in vitro* data to humans.

**References:** 1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971. 2. Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother.*, 1:164, 1972. 3. Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been estab-

lished. Sulfonamides should not be used for group A *B* hemolytic streptococcal infections and will not eradicate prevent sequelae (rheumatic fever, glomerulonephritis) of *S* infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purp or jaundice) may indicate serious blood disorders. Frequent (and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom drug-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** Blood dyscrasias (agranulocytosis)



# Encounter in Clinical Practice

## Control of primary bacterial offenders

Antibacterial Gantanol® (sulfamethoxazole) controls susceptible strains of *E. coli* and other gram-negative and gram-positive organisms

often implicated in acute nonobstructed pyelonephritis and cystitis.

## Prompt antibacterial blood and urine levels

In from 2 to 3 hours after the initial 2-Gm adult dose, antibacterial levels are present in

both the blood and urine.

## B.I.D./T.I.D. dosage for around-the-clock coverage

Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8 h. dosage regimen. Either schedule provides coverage during the waking

and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

## Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often re-

spond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents including sulfonamides, especially in chronic or recurrent u.t.i.

## Your Option: Tablets or Suspension

Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide

therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

**In nonobstructed cystitis and pyelonephritis due to susceptible organisms**

**Gantanol®**  
(sulfamethoxazole)  
**Basic Therapy**

ic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *skin reactions* (erythema multiforme, skin eruptions, epidermolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctivitis and scleral injection, photosensitization, arthralgia and myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and colitis); *CNS reactions* (headache, peripheral neuritis, depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, jaundice, nephrosis with oliguria and anuria, periarteritis nodosa and other phenomena). Due to certain chemical similarities with diuretics, goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of hypoglycemia, diuresis and hypoglycemia as well as thy-

roid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

**Usual adult dosage:** 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

**Usual child's dosage:** 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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## Editorials

### Caring for the Patient

One of the frequent reasons a patient sees his doctor is for relief of pain, while relieving pain is one of the most perplexing tasks confronting the practicing physician. First, one must understand several characteristics about the nature of pain which is basically a subjective emotional experience. For patient reaction varies tremendously from person to person and even in the same person from time to time, depending on a host of factors. As there is no pain without awareness, individual discernment of pain dictates its nature, for it is what the patient actually feels instead of our interpretation of how he says he feels.

In evaluating a patient's pain, one must look for emotional disorders, the patient's home and work environment and his cultural background. Fear, apprehension and anxiety may make a patient more sensitive to painful stimuli, as does the patient's age, state of nutrition or physical fitness. Pain may be multifaceted in origin, and a diagnosis of low back pain, tension headache, or peptic ulcer, should warn the physician not to attempt managing pain without looking for underlying causes. Too often, only the patient's pain is treated, either because he has difficulty describing it or else proper evaluation and therapy is too time-consuming. The point to remember is that the patient wishes to return to a normal life and not simply obtain relief of pain for the moment. A useful history, containing information on the location of the pain, its onset, distribution, quality, intensity, duration and what aggravates or relieves it is necessary. In the treatment of mild pain even though persistent, non-narcotic analgesics are often successful but the best drug is one that relieves the individual patient's pain without side effects. The optimal dosage is the smallest amount that works. Because a given dose of one analgesic has always seemed to work does not mean it always will. Chances are that when it doesn't work, the patient is not hypersensitive

or psychoneurotic but rather that the drug, the dosage or both are inadequate. Continuity of care is therefore necessary to assure that the drug and dosage prescribed are proper. Most non-addictive analgesics have no mood altering or soporific effect, so it may be useful to combine non-narcotic or weaker narcotic analgesics with some hypnotic.

In the treatment of chronic pain, selecting the best drug and dosage should be determined as with any treatment of pain, developing comfort for the patient, explaining the procedures and purposes to the patient and his family. Then making sure that the dose is adequate to control the pain, the drug should be given before pain reappears, using the "operant conditioning" strategy. Determine the average duration of pain relief produced by the chosen drug, then once this time is ascertained, the drug is given at fixed intervals just short of the predetermined period of relief, making administration not contingent on pain relief but rather on "non-pain" or well behavior. While drug abuse, dependency and addiction are ogres that everyone fears, conditions such as advanced age, terminal cancer or a chronic painful disease should be considered so that the patient's comfort and his usefulness to society are the deciding criteria. A cheerful greeting, an optimistic attitude, and listening to the patient in an unhurried atmosphere will build confidence in his physician. This is an important aspect, for every person with pain needs psychological support.

Acupuncture, hypnosis, behavior modification, new drugs, surgical procedures and new theories on pain reception all promise hope for the future. We should remain open-minded, ever ready to accept any new and proven method to relieve pain.

C.M.C.

#### Reference

Bonica, John J.: The Total Management of the Patient With Chronic Pain, Drug Therapy, Pp. 33-47, January 1973.

## Cough Mixture Proposal

The Commissioner of the Food and Drug Administration proposes to withdraw approval of 23 combination cough preparations including Phenergan, Actifed-C, Beynlin and other equally clinically valuable and effective mixtures. The stated reason is that "new information with respect to the drugs currently formulated, evaluated together with the evidence available at the time of approval of the application(s), shows there is a lack of substantial evidence that the drug(s) will have all the effects purported or represented to have under the conditions of use prescribed, recommended, or suggested in the labeling."

The quotation is from the Federal Register of February 9, volume 38, number 27, page 4007.

What is logical about the proposal? Neither the laboratory pharmacologist with his animals nor the investigator in the large outpatient clinics obtain and report the factual and true value of these formulations as seen by the vast observations of practicing physicians. The Federal Register notes that "The Food and Drug Administration has evaluated reports received from the National Academy of Sciences-National Research Council, Drug Efficacy Study Group."

Several factors should be considered by the FDA before any action is taken. The value of these formulations and reason for their use by physicians are important. Were they to be removed from availability, physicians would need to write

prescriptions for these ingredients separately when desired. This would mean separate compounding or dispensing by the pharmacist. Without his availability to the appropriate chemical facilities of the manufacturer for compounding the proper ratios, this, from a practical point of view, would prove unsafe for accuracy and probably impossible. Obviously the cost to the patient would pyramid. Dosage administration would present a staggering complexity. The physician would need to instruct patient to blend or accurately mix the various ingredients. As the cough improved the original dosage would have to be modified. The age of the patient would be an important consideration.

But these are not the factors which entered into the Commissioner's decision-making processes.

Unfortunately, physicians seldom learn of these many FDA proposals which have transpired over the past few years until after the changes are legislated. This may be the answer to the FDA's contention that few protests are received from physicians, that there is a lack of broad registered protest on their part.

They did know about this one—through a single publication received by a minority. Whether the protest to Washington was loud enough to be heard will not be known for a few months.

KENNETH PHILLIPS, M.D.

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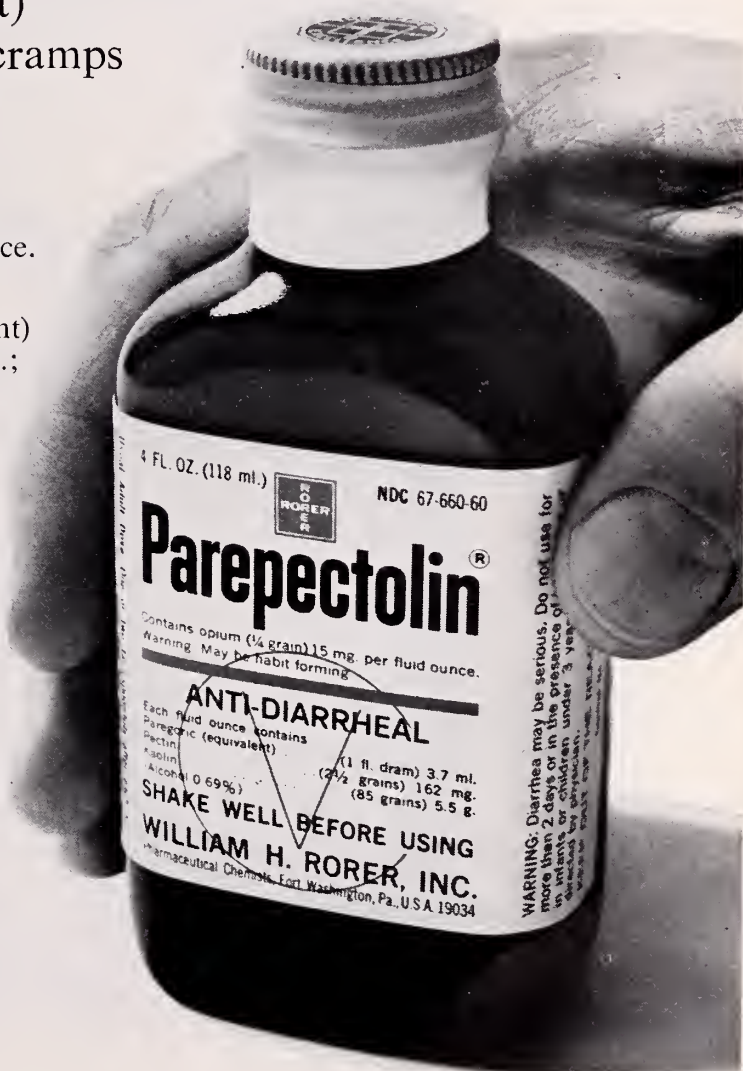
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(1 fl. dram) 3.7 ml.; Pectin ( $2\frac{1}{2}$  grains) 162 mg.;  
Kaolin (85 grains) 5.5 g.; (Alcohol 0.69%).

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## ORGANIZATION

### Our Retiring President



WILLIAM J. DEAN, M.D.

# A Significant Time

Early in his term as FMA's 96th President, Bill Dean enumerated organized medicine's most pressing problems—guilds, HMO's, national health insurance, peer review, medical care foundations, and postgraduate education with certification. Considering these, he implied that the practice of medicine had become frustrating: "Just trying to remain independent in a free enterprise system with third parties seeming to engulf us steadily from all directions has become a chore." This philosophy hinted at a pessimism which did not exist. Instead, he optimistically opened the way toward solutions at the first Board of Governors meeting, asking the Board to approve such wellknown names as Babers, Corso, Thames and Astler, and appointing some new ones to various councils and committees. He persuaded Dan Seckinger from Miami to lead the Committee on Drug Abuse which met seven times. Jim DeVito and Bob Windom took on the job as chairmen of the Council on Allied Professions and Vocations, and the Council on Voluntary Health Agencies, respectively. Jim Ingram from Tampa worked diligently as Chairman of the Council on Scientific Activities. Fred Andrews from Mount Dora, Mike Pickering from Lakeland, and Sanford Mullen from Jacksonville, following Bill's leadership, put in many hours to solve problems in Specialty Medicine, Continuing Medical Education and Legislation. A review of the Workmen's Compensation Fee Schedule was abetted by Joe Matthews and his subcommittee. The Woman's Auxiliary was called on to assist with the drug problem. Later, the ladies requested FMA to co-sponsor a statewide health education conference which was highly successful.

Regarding medical care foundations, a subcommittee under Jim Borland has the presidents of approved foundations over the state serving as members.

A Medicaid committee, ably guided by Allyn Giffin of St. Petersburg, began functioning to coordinate its activities with committees on government programs, legislation and public agencies. The problems caused by inadequate funding of the physicians services portion of Medicaid has

been brought to the Governor's attention and he has indicated a solution will be one of his priority objectives.

Jim Cook of Marianna was prevailed upon to write and complete incorporation papers for the Florida Physicians Association. Correspondence sent to each FMA member stating the Association's purposes has produced a modest favorable response.

After three years' experience on peer review under Jim Byrne's committee, the Florida Professional Standards Review Organization, Inc., has been authorized to serve as prime contractor with HEW for the entire state.

The Committee on Health Insurance, ably chaired by Mahon Myers, of Tampa, serves as liaison between physicians and the industry to provide better understanding of each other's points of view and resolve disagreements between FMA members and the insurance industry.

Bill worked closely with Harold Parham on a new professional liability insurance program. A contract was signed with the Argonaut Insurance Company and over one half of FMA members have obtained this plan of protection. Serving as general agent for the program is FLAMEDCO, Inc., a stock corporation wholly owned by FMA.

As Chairman of the Board, Dr. Dean guided the consideration of procedures, policies and opinions which as enacted will continue to affect the practice of medicine. With the Board of Governors, he protested local disclosure of the names of doctors subjected to peer review, agreeing with the consensus of the Board that "this requirement will destroy the Peer Review process in Florida."

He has had a busy year serving as chairman to efficiently and smoothly direct four meetings of the Board of Governors including a preceding executive committee meeting plus three additional ones to resolve crucial issues. He inspired us all at the Fifteenth Annual Leadership Conference in Orlando. He found time to speak at many civic meetings as well as to county societies and to our Auxiliary. He was able to enjoy a European Tour on an FMA sponsored medical seminar.



One final activity overshadows all his other efforts to find solutions to our problems, causing them to assume a secondary importance. It could have been predicted, actually, knowing something of his background. On Sunday morning, the final day of the 1973 annual meeting, FMA officers

and members will gather for a prayer breakfast being held in concert with the Committee on Medicine and Religion. It is fitting that this will be among Dr. Dean's final official actions as President.

C.M.C.

*What though on hamely fare  
we dine,  
Wear hoddin-grey and a'  
that;  
Gi'e fools their silks, and  
knaves their wine—  
A man's a man for a' that,  
Their tinsel show and a' that,  
The honest man, though ne'er  
sae puir,  
Is king o' men for a' that.*

*Robert Burns*

## Florida Wins Two AMPAC Top Achievement Awards

On Saturday, March 10, 1973, fourteen state PAC representatives received top membership awards from W. J. Lewis, M.D., Chairman of the AMPAC Board of Directors. The presentations were made in the International Ballroom of the Washington-Hilton Hotel in connection with the AMA/AMPAC Public Affairs Workshop.

Earning first place in two categories, 1972 FLAMPAC Chairman, Joseph VonThron, M.D., of Cocoa Beach, proudly accepted the bronze and wood engraved award from Chairman Lewis.

FLAMPAC's top achievements were in the categories of Highest Increase Over Prior Year and All Events.

First, second and third place awards were given in six membership categories. The categories are: Total Membership Contributions; Largest Contribution Per Member; Ratio of Members to Potential; Largest Total Women Members; Highest Increase Over Prior Years, and the sixth category, accumulation of the previous five categories, entitled All Events.



FMA members, following luncheon for Florida's Congressmen, display award. Standing (from left) Carl E. Andrews, M.D., Taylor H. Kirby, M.D., James C. Fleming, M.D., James W. Walker, M.D., Louis C. Murray, M.D., Jack Q. Cleveland M.D., Karl R. Rolls, M.D., Irving M. Essrig, M.D., Eugene G. Peek Jr., M.D. and John W. Glotfelty, M.D. Seated (from left) Sanford A. Mullen, M.D., Edward G. Haskell, M.D., William J. Dean, M.D., Joseph C. VonThron, M.D., Rufus K. Broadway, M.D. and James B. Byrne, M.D.

## In Memoriam

William C. Thomas Sr., M.D.



DR. THOMAS

The high standards of personal and professional integrity and ethics of Dr. William C. Thomas Sr., 71st President of the Florida Medical Association, have been embodied in the philosophy of the Chair of Obstetrics and Gynecology established in his honor at the University of Florida College of Medicine. Dr. Thomas led in foundation of the College in Gainesville as a member and chairman of several pioneering committees.

President Stephen C. O'Connell stated that the University was privileged to honor Dr. Thomas' memory. "He exemplified the finest human qualities in medical practice and in leadership on behalf of medical education."

A contribution of \$275,000 to the Department of Obstetrics and Gynecology began endowment of the Chair. The goal is \$750,000. President O'Connell stated: "It is our sincere hope that friends and colleagues will bring funding of this Chair to fruition and that teaching by its occupants will inspire future medical students to follow Dr. Thomas' example."

Leaders of medical groups in which Dr. Thomas held membership have honored him in tributes and resolutions.

Dr. George A. Dell of Gainesville, president of the Alachua County Medical Society, remembers Dr. Thomas as a physician who "possessed exquisite sensitivity to the needs of the human spirit as well as the human body and utilized this insight to restore and to maintain the health of his patients."

"To him the practice of medicine meant a constant outreach to human beings. Those who can tell this best—the beneficiaries of his care—can be found across the state and throughout the land."

Dr. C. H. Gilliland of Gainesville, president of the Florida Obstetric and Gynecologic Society, recalls that Dr. Thomas set the example for all new physicians and that his standards influenced the practice of medicine in all Florida, especially north central Florida.

Dr. Gilliland relates: "When I first entered practice in Gainesville, Dr. Thomas and his asso-

ciate were very busy. Consequently some of his patients gravitated to me. When he saw their names on the obstetrical floor he would go to their room, congratulate them on their baby, and then tell them what a fine doctor they had. How many of us can do that when one of our patients 'deserts' us!"

"This will be the first Christmas in many years that Dr. Thomas will not be making his rounds of friends homes with bags of Chinese Honey Oranges. He would walk in unannounced, visit a few minutes then on to the next house."

Dr. Gilliland describes Dr. Thomas' manners as "invariably courtly" and his speech as pure. "It was indeed rare that he spoke disparagingly of anyone."

"For many years and until the very week prior to his final illness he made daily rounds on every

patient on the obstetrical floor and visited with every patient regardless of who their own physician might be. On the few occasions when he was a patient, he would pad down the hallways late at night and visit other patients."

"I believe that each physician who knew this great humanitarian is just a little better man and just a little greater physician for the experience. May each of us resolve to pass on some of the warmth and richness of his personality to the next generation of physicians."

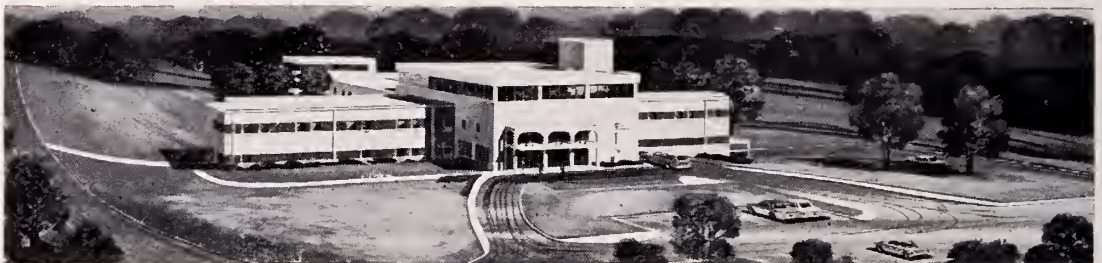
Dr. Thomas served as FMA President in 1947 and during 48 years of active practice in Gainesville had been a member and officer of numerous general medicine and specialty organizations. He died on July 31, 1972. His son, Dr. William C. Thomas Jr., is Professor of Medicine at the University of Florida College of Medicine.

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## Letters

### An Open Letter

Dear Son:

"So you want to be a doctor. Remember, dealing with the public is hard enough but dealing with the public when it is sick is very trying." This is what a doctor friend of the family told me before I went to medical school. He was aware of problems, but I wonder if he had considered medicine as a science and art, religion and profession, business and avocation.

Medicine is a science of itself, yet draws from other sciences and blends this knowledge together in the healing of each patient. The physician, then, needs to know more about electronics, drugs, x-rays and chemistry in all its modalities. Electronmicroscopy, and electrochemical and immunological techniques are probing the cellulophysiology of cancer and genetics. Frontiers are being challenged.

The art of medicine is the combination of the physician's knowledge of healing with the personality of the patient to achieve a cure. Its practice will tax your ingenuity and ability to the fullest. For instance, we have no exact measurement for pain and, perhaps, trying to evaluate it is the most challenging facet of the art. Too, cures are not always assured. Some patients do not want to get well; then there are those who enjoy illness as an escape. The pain and sickness of some can be relieved by a court settlement.

The religion of medicine involves helping and the opportunities are unlimited, varying from the missionary field to the local community. Your attitude and approach to the patient and his illness influences the will to live which may be at a low ebb. The patient may need not only your help but the spiritual guidance of the minister, priest or rabbi, and you may be called upon to serve in their place. There will be times when you prolong life only at the expense of prolonging misery; then you and the family members must decide if the quality is worth the quantity. There

may be times when your skills and abilities will be needed to save a life that appears worthless, such as that of the murderer or rapist, and you will wonder: will he be changed? Your need is to solve the problem by combining your faith with the science and art of healing. The patient's will to live may be the deciding factor. Then, there are times when you must have compassion; yet not become a victim of those who would abuse your commiseration.

The profession of medicine has many aspects, from research to teaching, solo practice to mixed groups, and family practice to all the specialties. Each has advantages and you can gain a degree of immortality from any of them.

You do not have to be among a group of physicians very long to recognize those dedicated to the well-being of the patient.

Each patient must have extensive, careful work-up and treatment, not only to prevent possible legal entanglements but to make sure that the problem is cause and effect, not coincidentalism. The obvious is not always the cause. Without loss of individual responsibility there must be teamwork in patient care, with intercourse of ideas and cooperation of effort without financial rape. There must be proper respect for another's ability and time, and competition so that you are kept medically alert and financially reasonable. If you pass the buck, sometime it will be your dough.

Medicine has organizational aspects associated with patient care. You need to participate to help maintain a high standard, to pass on to future physicians the knowledge and ideals you have acquired.

Medicine is a business. Standards are being set up, called relative values of the worth of certain procedures. The catch is that no two cases are ever exactly alike, which makes the practice of medicine interesting and challenging. It also is frustrating when rendering an opinion regarding the value of services. You should charge for each

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This letter to his son was written by Carl E. Andrews, M.D., 705 North Olive Avenue, West Palm Beach 33401.

one; sometime the patient can only express payment in goodwill. If the service is rendered with love and charity, the patient benefits.

The government is beginning to control medicine through many means: Health Planning Councils, Mandatory Certificates of Need, fees and possibly where and how to practice. Medical care has been declared a right, not a privilege. This may be retribution upon physicians for not practicing professional tithing.

The avocation of medicine is that part which you enjoy so much—the academic fellowship of physicians and studying to keep up-to-date—when you are not caring for patients. The man who designated the end of schooling as “commencement” chose an excellent word; it is then that you begin to apply what you have learned. You must keep up-to-date and it can be work or play. As your grandmother said, “the only difference between work and play is mental attitude.”

You need some time for yourself because He who said “six days shalt thou labour” gave good advice. Regardless of how well you plan your time the call of a patient in distress will interrupt the hobbies and pleasures you use to rejuvenate the body. Start this early. You have four years of medical school, three to eight years of training for a specialty and you need good health to go out then and earn a living for yourself and your family.

There is humor, and sadness too, in the practice of medicine. At times it is difficult to keep a straight face at the expressions of a patient, and a good sense of humor is important. So is a serious optimism. Patients don't like long faces, but they quickly detect negative attitudes and situations.

Sickness often means sadness. When you have exhausted all your knowledge and skills to cure a patient to no avail, you must understand “that which is so universal as death must be a blessing.”

If you can keep as your goal helping your fellow man, many problems will seek their proper perspective. There is no other field in which you can help as much as in medicine, no other profession that requires so much responsibility. If you do your job to the best of your ability, you will respect yourself and gain the respect of others.

You said you wanted to become a doctor. You have what is required. I know you will make the grade.

Best wishes.

“PAPA DOC”

Dear Editor:

I feel that I must point out something to my colleagues with regard to the statement on abortion by Attorney General Shevin, which appeared on page 58 of the March 1973 issue of the Journal of the FMA, which may have been overlooked by them.

Our hospital attorneys have pointed out that while the Supreme Court and Mr. Shevin have stated that an 18 year old female may obtain an abortion without her parents' permission, the physician performing the abortion is protected from prosecution only under the *criminal statutes*. The laws of Florida still require the consent of the parents to *any surgical procedure* on one under age 21 unless they are emancipated by court order or by marriage. Failure to obtain the proper parental consent could lead to *civil damages or suit* for a trespass (assault and battery).

In addition, should a complication arise that requires immediate exploratory surgical intervention (i.e., a perforated uterus), proper consent for the abdominal procedure would not be available.

I would urge all my colleagues to continue to obtain parental consent for abortions in unmarried girls under age 21.

STEVEN M. WEISSBERG, M.D.  
SOUTH MIAMI

---

Not gold but only men can make  
A people great and strong;  
Men who for truth and honor's sake  
Stand fast and suffer long.

Brave men who work while others sleep,  
Who dare while others fly—  
They build a nation's pillars deep  
And lift them to the sky.

Ralph Waldo Emerson



## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Current Concepts in Radiology** edited by E. James Potchen, M.D. Pp. 346. 502 Illustrations. Price \$24.75. St. Louis, The C. V. Mosby Company, 1972.

**Is My Baby All Right?** by Virginia Apgar, M.D. and Joan Beck. Pp. 492. Illustrated. Price \$9.95. New York, Trident Press, 1973.

**Renal Disease in Childhood** by John A. James, M.B. Pp. 377. 116 Illustrations. Price \$23.50. St. Louis, The C. V. Mosby Company, 1972.

**Family Planning Education, Parenthood and Social Disease Control** by Charles William Hubbard, B.S., M.P.H. Pp. 173. 48 Illustrations. Price \$3.95. St. Louis, The C. V. Mosby Company, 1973.

**Heritable Disorders of Connective Tissue**, 4th Ed. by Victor A. McKusick, M.D. Pp. 878. 1099 Illustrations. Price \$32.50. St. Louis, The C. V. Mosby Company, 1972.

**Current Diagnosis Treatment** by Marcus A. Krupp, M.D. and Milton J. Chatton. Pp. 996. Price \$12.00. Los Altos, Calif., Lange Medical Publications, 1973.

**Mental Health and Social Change, An Annotated Bibliography** edited by George V. Coelho. Pp. 458. Price \$3. Washington, D. C., U.S. Government Printing Office, 1972.

**Handbook of Pediatrics** by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. Pp. 693. Price \$6.50. Los Altos, California, Lange Medical Publications, 1973.

# Rondomycin<sup>®</sup> (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.** Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines. To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanel, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** "Rondomycin" (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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## Book Reviews

**Biofeedback and Self Control**, an Aldine Reader on the Regulation of Bodily Processes and Consciousness, editors Theodore Barker, Leo V. Dicara, Joe Kamiya, Neal E. Miller, David Shapiro and Johann Stoyva. Pp. 806. Price \$17.50. Chicago, Aldine-Atherton, 1971.

This book contains a collection of 75 articles on psychophysiology selected by an outstanding panel of experts; all having appeared in print elsewhere, some as early as 1957. The book contains the most important papers on this subject, according to the editors, to 1969. An annual publication of the most important papers on psychophysiological research as companion pieces is planned.

The first article is entitled "Learning of Visceral and Glandular Responses" by Neal E. Miller, Ph.D., Professor and Head of a Laboratory of Physiological Psychology, Rockefeller University. This article appeared in *Science* in 1969. It gives an overview of the important and exciting research in this area. By a series of rewards and punishments with laboratory rats, Dr. Miller has been able to train these animals to vary the heart rate, vary the gut motility and even vary the rate of urine flow. By a series of rewards by stimulation of the brain, he could train rats to slow the heart rate to such degree that some of the rats would die! Implications for humans are discussed. If a mother ignores headache or tachycardia in a nervous school child on the day of an examination but keeps him home because of vomiting, then the latter symptom is reinforced and is likely to persist whereas other symptoms not rewarded will likely be extinguished. There are sections devoted to blood pressure and vasomotor responses; electrodermal activity; EEG activity; hypnosis; Yoga, Zen and autogenic training.

Many of these articles will already be familiar to those physicians interested in psychophysiology. It will have limited appeal, if any, to the average practicing physician.

This book would have a place in the hospital or medical school library. Occasionally a physician might wish to refer a patient to this book in

order to convince him/her that biofeedback is extremely complicated. If any of my patients want more information about a recent simplistic article in the June Ladies Home Journal entitled "How to relieve Headaches by Warming Your Hands," I know just where to send them.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Advances in Forensic and Clinical Toxicology** by A. S. Curry. Pp. 280. Illustrated. Price \$32.50. Cleveland, Ohio, CRC Press, 1972.

The Chemical Rubber Company Press publishes a truly astounding array of handbooks, review journals and manuals relating to a variety of scientific disciplines. Medical subjects include biochemistry, microbiology, and radiologic sciences. This hard bound volume, retailing at \$32.50, written in delightful prose by an Englishman, deals with current concepts, methodology and clinical implications of forensic and clinical toxicology.

Recognition and quantitation of "poisons" is becoming increasingly important in all phases of medicine. Even a small laboratory must be abreast of identification procedures using personnel and instrumentation available. As this volume points out, contributions to the literature are overwhelming, and a reference manual of this sort is invaluable. Chapters include information about common poisons, i.e., carbon monoxide, alcohol, barbiturates, pesticides, etc., as well as drugs of abuse, metals and new prescription and over the counter pharmaceuticals.

Plants, fungi and fish poisons are also described with many references given. The index of reference is very complete and will be most helpful to the toxicologist or laboratory director.

The book is strongly recommended to all those engaged in the detection of poisons.

COURTLANDT D. BERRY, M.D.  
NAPLES

# MEETINGS

## Approved by FMA Committee on Continuing Education

### MAY

- 18 Acupuncture — Electrical Stimulation — A Critical Review With Demonstrations in Pain Control Techniques, University of Florida, Gainesville. For information: Division of Continuing Education, University of Florida, Box 758, Gainesville 32601.
- 18-19 Exercise as a Diagnostic and Treatment Tool in Coronary Disease, Cedars of Lebanon Hospital Auditorium, Miami. For information: Mary E. Cunningham, R.N., Cedars of Lebanon Hospital, Box 793, Miami 33152.
- 25 "Diseases of the Vulva and Ovary and Trophoblastic Disease," Sacred Heart Children's Hospital, Pensacola. For information: William H. McCaw, M.D., University Hospital, 1200 West Leonard St., Pensacola 32501.
- 28-30 Fourth Annual Topics in Internal Medicine, University of Florida College of Medicine, Gainesville. For information: Division of Continuing Education, Box 758, Gainesville 32601. (Dates changed from May 9-11).
- 29-31 Master Interpretation of Clinical Electrophysiology, Contemporary Hotel, Disney World, Lake Buena Vista, Florida. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

### JUNE

- 11-16 Seventh Annual Workshop in Electrocardiography, Tides Hotel and Bath Club, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

## National and Regional Meetings Held in Florida

### MAY

- 3- 5 Association of Clinical Scientists, Hawaiian Village, Tampa. For information: F. William Sunderman Jr., M.D., University of Connecticut School of Medicine, Drawer B., Newington 06111.
- 3- 7 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. For information: Robert D. Reinecke, M.D., Albany Medical College, Albany, N. Y. 12208.
- 6-12 American Society for Microbiology, Fontainebleau Hotel, Miami Beach. For information: Mr. R. W. Sarber, 1913 I St., N.W., Washington, D. C. 20006.
- 12-14 American Association of Blue Shield Plans, Diplomat Hotel, Hollywood, Fla. For information: Jean A. Borger, 211 E. Chicago Ave., Chicago 60611.
- 21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Donald F. Richardson, One East Wacker Dr., Chicago 60601.

### JUNE

- 11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

### OCTOBER

- 21-25 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Miami Beach. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

### NOVEMBER

- 8-10 Gerontological Society, Deauville Hotel, Miami Beach. Exec. Dir.: Mr. Edwin Kas-kowitz, 1 Dupont Circle, Washington, D.C. 20036.
- 11-16 American Association of Blood Banks, Americana Hotel, Miami Beach. Central Office Manager: Miss Lois J. James, 30 North Michigan Avenue, Chicago 60602.

Next FMA Annual Meeting: May 9-13, 1973, Bal Harbour



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## Classified Ads

### physicians wanted

#### Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

FAMILY PRACTITIONER to join 15 man multispecialty group in Central Florida. Excellent fringe benefits together with pleasant working facilities in an area famous for excellent recreational opportunities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

FAMILY PRACTITIONER to join 4 man hospital based group in North-Central Florida. Pleasant working conditions and excellent salary. Contact Don F. Beazley, Administrator, Division Hospital, Box 587, Lake City, Florida 32055, phone (904) 752-2922.

WANTED, TWO GP'S, Florida licensed, to join 3-man group. Large general and industrial practice; OB and minor surgery in Southern Central Florida town. Equipped office adjacent to fully accredited hospital. Excellent outdoor sports on Lake Okeechobee. Salary open. Reply to: J. D. Forbes, M.D., P.O. Box 668, Clewiston, Florida 33440.

WANTED: GENERALISTS AND FAMILY PRACTITIONERS. Part-time or full-time. Physicians to participate in systemized clinics in Miami, Florida area. Guaranteed payment for service. No night call or hospital work required. Minimum paper and busy-work. Rewarding and lucrative. Evening and weekend hours also available. Call Dr. Dayton: (305) 681-4602(03).

FAMILY PRACTITIONER to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

SEEKING FAMILY PRACTITIONER: Pleasant rural community, well established, growing community in central Florida. Located in center of horse country, good fishing on O'ange Lake. Near state teaching hospital. Clinic building available. Contact Town Council, P.O. Box 138, McIntosh, Florida 32664. Phone (904) 591-1214.

#### Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST, board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

INTERNIST-CARDIOLOGIST, Board certified or board eligible to work along with our present Internist-Cardiologist. Long established group in Hollywood, Florida. Must have Florida license and completed military obligation. Salary open. Write John F. Kerwick, Manager, P. O. Box 2308, Hollywood, Florida 33022.

TWO BOARD CERTIFIED INTERNISTS (55 & 35) seek young, board qualified, third internist. Good working conditions. Must have Florida license and no military obligation. Please send curriculum vitae with first letter. Contact Drs. Stone and Fineman, P. A., 1755 Adams Street, Hollywood, Florida 33020.

INTERNIST WANTED: To join busy board certified internist in growing suburban area central east coast of Florida. Excellent hospital and residential facilities. Write C-593, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST POSITION AVAILABLE soon AP-CP and Florida boards required. Small group North Florida. Great climate, beautiful area, stimulating professional atmosphere. Reasonable financial arrangements. Write C-594, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN FOR ASSOCIATION: With pediatrician in busy central Florida area. Salary first year, percentage and partnership to follow. Florida license required. Write C-584, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIST: For Veterans Administration Outpatient Clinic. Work consists of outpatient treatment and evaluations for compensation and pension purposes. Forty hour work week. Salary commensurate with qualifications. Excellent fringe benefits and retirement. Florida license not required. Contact John C. Wells Jr., M.D., Chief of Clinics, P.O. Box 13594, St. Petersburg, Florida 33733 or phone (813) 893-3526 for additional information or application forms.

**INTERNIST WANTED:** Preferably cardiologist, to join board certified cardiologist-internist in Dade County area. Military obligation must be completed. Write C-600, P.O. Box 2411, Jacksonville, Florida 32203.

## Miscellaneous

**ADDITIONAL PHYSICIANS URGENTLY NEEDED:** GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

**DUNEDIN,** Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

**PHYSICIANS NEEDED:** Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners, Internists, and Allergist. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

**EMERGENCY ROOM PHYSICIAN**—Immediate opening available for Florida licensed physician. Large modern medical center with all supportive services. Excellent working conditions, liberal benefits and flexible scheduling of approximately 40 hours per week. For more details contact Jack T. Stephens Jr., Broward General Medical Center, 1600 South Andrews Avenue, Fort Lauderdale, Florida 33316. Phone (305) 525-5411, Ext. 631.

**DEVELOPING MULTISPECIALTY GROUP** oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Urologist, Internist, Cardiologist, Pediatrician, General Surgeon, Orthopaedist, and OB-GYN. Contact: H. D. Williams, M.D., President, Marlowe, Williams, Abbey & Sells, MDs, PA, Richey Medical Center, P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

**HOUSE PHYSICIANS.** For a full-service 530 bed community hospital serving South Broward County. Duties include in-house coverage, uncomplicated deliveries on assigned patients, and histories and physicals on assigned patients. Florida license desirable but not essential if ECFMG certificate or valid out of state license. Contact H. B. Weinberg, M.D., Director of Medical Education, Memorial Hospital, 3501 Johnson St., Hollywood, Florida 33021 or phone (305) 987-2000.

**CENTRAL FLORIDA AREA:** Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

**PHYSICIAN WANTED:** Miami area, no hospital work or house calls. Group practice. Suitable for man who wishes to work 30-40 hours per week and devote time to family and recreational activities. Will consider part time or semi-retired. Florida license required. Write C-599, P.O. Box 2411, Jacksonville, Florida 32203.

**MEDICAL DIRECTOR POSITION OPEN:** Comprehensive drug abuse treatment program including methadone treatment. Physicals, general medical care, dosage settings for 200 methadone patients, and 100+ drug free patients. Functions could be performed by individual or group. Minimum requirements M.D., Fla. license, class A narcotics license. Specialization in psychiatry or internal medicine preferred but not required. Salary open up to \$35,000/yr, commensurate with experience. Send resume or inquire: James Poage, Executive Director, LIFE Drug Program, 15 S. Lee St., Jacksonville, Florida 32204. (904) 358-1733.

**INTERNISTS, ORTHOPEDIC SURGEONS,** and other sub-specialties. Investigate Plant City, Florida to set up private practice. 129-bed hospital with nuclear medicine department. 58 additional beds available and equipped. Located between Lakeland and Tampa. Contact H. F. Holmes, Administrator, South Florida Baptist Hospital, Plant City, Florida 33566.

**PHYSICIANS WANTED:** St. Augustine (Flagler Hospital) desires the following Florida licensed physicians to meet the growing community needs: General Practitioners (2), E.R. Physicians, Internist, General Surgeon, Pediatrician, Otolaryngologist, Ophthalmologist. New professional building ready in July. Financial assistance available. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone (904) 829-5676.



## situations wanted

**RHEUMATOLOGIST**, age 30, taking internal medicine boards June 1973. Two year rheumatology fellowship completed fall 1973, desires association, group or hospital position in southeast Florida. Married, military obligation completed. Write C-587, P.O. Box 2411, Jacksonville, Florida 32203 or call (301) 460-4698.

**OBSTETRICS-GYNECOLOGY and GENERAL SURGERY**: Board eligible, Florida licensed, general surgeon and obstetrician-gynecologist, seeking group association or partnership in central Florida (Lake-land-Orlando area). Available immediately. Write C-561, P.O. Box 2411, Jacksonville, Florida 32203.

**UROLOGIST**: Board certified, 36 years old, university trained, F.A.C.S.-F.I.C.S. Five years in private practice, desires to move to a warmer climate. Write C-588, P.O. Box 2411, Jacksonville, Florida 32203.

**PHYSICIAN ASSISTANT**—Graduates in June, Northeastern University. Three years Navy Corpsman. Currently completing internship at University of Florida. Desires position with general practice, group or solo GP. Write Brent L. Harrell, 3230 S. W. Archer Rd., Apartment 158 L, Gainesville, Florida 32601. Phone (904) 373-5341.

**INTERNIST-CARDIOLOGIST** seeks association in south or central Florida, preferably coastal. Age 39. Internal medicine boards. Full cardiology training. Florida license. Military obligation completed. Available fall 1973. Write C-597, P.O. Box 2411, Jacksonville, Florida 32203.

**POSITION WANTED**: Cardiologist experienced, desires association with group needing cardiologist or group practicing internal medicine on a part or full time basis. Equipped with all noninvasive instrumentation including vectorcardiography for diagnosis in cardiology. Interested in Pinellas, Dade, Broward and Palm Beach counties. Available after summer, 1973. Write C-598, P.O. Box 2411, Jacksonville, Florida 32203.

**ENT MAN, CERTIFIED**—60 years of age desires association. Willing to take salary. Anxious to do office practice, some surgery, ENT, allergy including Rinkel's Titration, Provocative food testing and Cytotoxic food testing. Interested in Pinellas, Dade, Broward and Palm Beach counties. Available after summer, 1973. Write C-595, P.O. Box 2411, Jacksonville, Florida 32203.

**OTOLARYNGOLOGIST**, board eligible, Florida licensed, seeking association or partnership in Florida. Available July 1st, 1973. Write Uday Dave, M.D., 74-47 260th Street, Glen Oaks, New York, New York 11004, or contact hospital phone (212) 343-6700, or residence phone (212) 343-1948.

## practices available

**PEDIATRIC PRACTICE FOR SALE**. Well established 12 year old practice. Gross \$106,000. Southeast Florida coastal community. Not far from Miami. Excellent fishing and water sports; lovely weather. Modern, completely equipped condominium office. New hospital. Excellent terms, may purchase or lease complete package. Available July 1973. Write C-583, P.O. Box 2411, Jacksonville, Florida 32203.

**GENERAL PRACTICE AVAILABLE WITHOUT COST**: Would like someone to take over 3 year lease and assume payment of equipment which does not include x-ray, but has Burdick EKG, and ultra-sound, Welch-Allyn wall unit, Sigmoidoscope fiber-optic, complete laboratory and office furniture. Write C-592, P.O. Box 2411, Jacksonville, Florida 32203 or phone (305) 573-4929.

**SARASOTA, FLORIDA—WELL-ESTABLISHED INTERNAL MEDICINE PRACTICE** available due to sudden death of physician. Excellent location. Laboratory next door. Annual gross and net excellent. Enquiries to W. G. Sutherland, M.D., 5120 Riverwood Avenue, Sarasota, Florida 33581. Phone (813) 924-5528.

## real estate

**EXCELLENT OFFICE SPACE AVAILABLE**: 975 sq. ft. in the Five Points Medical Center, Oak and Lomax Sts., Jacksonville, Florida 32204. All utilities and services furnished. Will renovate to suit tenant. For information please call Dr. Max Mendelson at 355-5150.

**PRIVATE SUITES FOR IMMEDIATE OCCUPANCY**: New 18,000 sq. ft. building with excellent parking. South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

**OUTSTANDING LOCATION FOR SPECIALIST**: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

**RENTAL: LUXURY MOUNTAIN CHALET**. Beech Mt., North Carolina, 4 bedrooms, 4 baths, sleeps 10. Sauna, pool, fireplace, all electric kitchen, full recreational facilities including ping pong and pool table. Swiss Alpine Village setting in magnificent natural surroundings. Golf, tennis, swimming and Land Of Oz. Information and rates: P.O. Box 10064, Jacksonville, Florida 32207.

**FAST GROWING OCALA**: New 125-bed Hospital of America opening in July 1973. Physician suites available July 1, in long established medical center. Central location, unlimited parking, all utilities and janitor services furnished. Will renovate to suite leaser. E. E. Conrad, owner-manager, P.O. Box 216, Silver Springs, Florida 32688. Phone (904) 236-2343.

**NEW ONE STORY PROFESSIONAL BUILDING**—Immediate occupancy, will complete interior to suit doctor's needs. Plenty of parking. South Federal Highway, Hollywood, Florida. Between several hospitals. Contact Dr. Krieg, 1055 South Federal Highway, Hollywood, Florida 33020, or call (305) 920-3232.

# Florida Regional Medical Program

## Supplement

To the Journal of the Florida Medical Association

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# Florida Regional Medical Program

## An Overview

GRANVILLE W. LARIMORE, M.D., GORDON R. ENGBRETSON, PH.D.,  
AND COYLE E. MOORE, PH.D.

The Florida Regional Medical Program is one of 56 established under Public Law 89-239. The law sets forth the purposes as:

Through grants to encourage and assist in the development of regional cooperative arrangements . . . to afford the medical profession and the medical institutions of the nation through such cooperative arrangements, the opportunity of making available to their patients the latest advances in diagnosis and treatment . . . by these means to improve generally the health manpower and facilities available to the nation and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators and representatives from appropriate voluntary health agencies.

The original law spoke to the area of "heart disease, cancer, stroke and related diseases." Subsequent amendments (Public Law 91-515) and administrative practice broadened the scope of the Program and enabled the regions to operate in other areas of need as determined by the regions themselves.

The Florida Regional Medical Program (FRMP) stated as its objective:

"To raise the levels of health care in Florida by assisting physicians, allied health personnel and their medical institutions in providing the highest quality health services in their own communities, increase accessibility and availability of these services and to promote the most modern health services with special attention to heart disease, cancer, stroke, kidney disease and related diseases."

### Program Characteristics

There are three unique characteristics which tend to set regional medical programs apart from

other federally funded activities in the health field. These are:

1. Local decision-making: Decisions regarding the assessment of need, determination of priorities and allocation of funds among approved projects are all made within the region. (In the Florida Program, the "region" includes the entire state, others of the 56 regions are made up of parts of a state or combinations of states or, in the case of 34 regions, consist of a single state like Florida). In each region provision is made in the decision-making process for maximum participation by those most knowledgeable about the region's health needs.

2. Cooperative arrangements: Public Law 89-239 calls for "regional cooperative arrangements" and one of the accomplishments of the Program has been to bring together all of those concerned with health services in the interest of developing the cooperative arrangements which are the foundation of all regional medical program activities.

3. Provider orientation: While there is consumer representation on the Regional Advisory Group, the policy-making body for the Program, it and all of the expert committees involved are dominated by health care providers. Of the 350 volunteers who provide expertise and guidance for the Florida Regional Medical Program, over 300 are physicians or other health professionals with physicians in by far the majority.

In fact, physicians have occupied a key role in the Florida Regional Medical Program from its very inception. It was the Florida Medical Association acting through the Florida Medical Foundation that served as the initial fiscal guarantor of the Program. This action enabled the Program to get under way after some months of uncertainty.

Dr. Larimore is Director and Dr. Engbretson Deputy Director, Florida Regional Medical Program. Dr. Moore is Chairman of the Florida Regional Advisory Group.

This work is supported by funds provided by Title IX of the Public Health Act. The findings and conclusions reported do not necessarily represent the views of the Public Health Service.

Florida was one of the first states to express interest in Public Law 89-239 which was signed in October 1965. It was not, however, until early 1968 that the Florida Program received its first funds and not until late October of that year that a state office was opened. Recruitment of staff required several months so that the Program did not actually become fully operational until early 1969.

The Program is operated by a nonprofit corporation, Florida Regional Medical Program, Inc., whose Board of Directors is composed of 11 physicians, a hospital administrator, a banker and a lawyer. The wisdom of Florida's medical leadership in utilizing the nonprofit corporation format has been amply demonstrated by experience. Other programs have now followed a similar plan so that currently 19 of the 56 programs in the nation are operated under such a corporate structure.

The regional medical program concept is almost tailor-made for Florida. The state's rapidly growing population, its large number of visitors (23 million in 1972), its high percentage of older citizens (15% over 65), its lack until recent years of medical schools and their accompanying research and clinical centers, all have resulted in medical service problems which are unique. This uniqueness greatly lessens the possibility of the state's problems being solved by set formulae or by the rigid dictates of mechanisms developed on a nationwide base. The regional medical program concept with its opportunity for local decision-making enables Florida to use allotted funds in the most effective manner possible.

## Roles and Responsibilities

To be certain that the local decision-making process operates with maximum efficiency, full opportunity is provided for input by physicians and others most knowledgeable about Florida's problems, needs and available resources. The table schematically represents the roles and responsibilities of FRMP's various review bodies in the development and review process.

FRMP's strong and active Regional Advisory Group consists of practicing physicians and representatives of organized labor, nursing, social services and social agencies, postgraduate education, CHP-a and -b agencies, state and local government, volunteer health organizations, Florida Bar Association, allied health professions, dental education, vocational and social services, hospital administrators, senior citizens, community hospitals, Hill-Burton agency and minority populations.

A planning process takes into account the health care deficiencies and needs of Florida, and relates projects to overall Program priorities. The Program has been diligent in developing a workable plan for solving health care problems through a mixture of staff activities, feasibility and demonstration projects, long- and short-term project activities.

During the developmental years, procedures for operation were developed and instituted which gave the FRMP, Inc., and the FRAG\* an effective means for establishing a program direction and exercising control. As experience was gained, or new means of operation were indicated, the policies, procedures and processes were refined accordingly.

\*Florida Regional Advisory Group

## FRMP PROGRAM DEVELOPMENT AND REVIEW PROCESS

	FRMP GOALS	LETTER OF INTENT	PREPARATION OF PROJECT PROPOSAL
Responsible Parties	Regional Advisory Group	Proposer with FRMP staff	Proposer with FRMP staff
Review Body	Planning Committee	FRMP staff and CHP a or b agency	FRMP staff
Procedures	Assess compatability with FRMP goals and priorities	Brief summary consistent with FRMP goals	What is to be accomplished and how
Principal Activities	1. Analyze RMPS policy and directions 2. Review local needs 3. Synthesize approaches to meeting local and national needs	Describe briefly what is to be accomplished, why and and estimated costs.	1. Extent of problem 2. Stated objectives 3. Methods 4. Evaluation 5. Budget

In the Florida Regional Medical Program, the responsibility for planning lies with the Florida Regional Advisory Group. Basic to its planning role, the FRAG solicits input, information, data, opinions, reports, from those to be served. Such input comes from the membership of the Group itself among whose members are providers of health care services.

Health and educational institutions, agency and organization representatives on the Group likewise provide input necessary for the planning process. The State Comprehensive Health Planning agency as well as local health planning councils, medical association, nurses association, hospital association, representatives of voluntary health organizations and others are examples of agency and organization participation.

Planning requirements of a more sophisticated scientific and technologic nature are satisfied through input furnished to the FRAG from its special advisory Task Forces, Councils and Committees. Membership on these groups consists of eminent Floridians with expert knowledge and experience about special diseases or health care problems. These experts along with staff, advise the FRAG of scientific and technologic advances, innovative approaches to the delivery of health care, new application of existing knowledge, or the need to develop new or to use more effectively existing health manpower.

The Board of Directors of the FRMP, Inc.—made up of the deans of the medical schools, rep-

resentatives of the voluntary and public health agencies, hospital administrators and practicing physicians—likewise has an opportunity to contribute to the FRAG's planning activity. While the role of Board members is confined to managerial affairs of FRMP, Inc., their advice and participation is solicited by the Group. Experts in their own right in various health problems and health care delivery systems, members of the Board have, on a number of occasions, suggested solutions to some of Florida's health problems.

### Evaluation

The Florida Regional Medical Program begins its evaluation process at the inception of a project idea. Various ideas are considered in light of FRMP objectives and are weighed for their potential contribution toward reaching the objectives of the Program. If project ideas are determined to have merit, a staff member is assigned to assist the applicant in preparing his formal application materials. Counsel is provided the applicant regarding clarification of his objectives, development of methodologies which will assist him in reaching these objectives, and elucidation of an evaluation procedure which will provide ways of measuring progress toward the project objectives.

In some instances, FRMP staff have assisted project directors to establish standards of performance against which to measure progress. Reporting systems designed to aid project directors in assembling data in a form which can be readily

PROJECT TECHNICAL REVIEW	PROJECT PROPOSAL FUNDING RECOMMENDATIONS DECISIONS	FRMP PROGRAM MANAGEMENT
Task Force/Councils FRMP staff	Regional Advisory Group	Board of Directors, FRMP, Inc. FRMP Director
Regional Advisory Group Planning and Evaluation Committee, Site Team Task Force/Councils CHP a or b agency	Planning and Evaluation Committee Regional Advisory Group	1. Receive, administer and account for funds 2. Review affiliation agreements with respect to: <ul style="list-style-type: none"> <li>a. Eligibility for and conformance with federal funding require- ments</li> <li>b. Capabilities of affiliates to manage grant funds</li> <li>c. Fiscal and administrative procedures</li> <li>d. Provisional and final indirect cost for affiliates</li> </ul>
Assess anticipated and real success	Recommend allocations of funds	Manage FRMP funds in accordance with federal regulations.
1. Determine merit of new proposal/contract 2. Provide ongoing review 3. Recommended changes	Allocate funds	



analyzed have been developed. An example of a data reporting system is one designed to assist in the analysis of various medical treatments rendered to patients in and out of coronary care units to determine the most effective methods.

Project directors are required to furnish monthly reports describing project activities, difficulties encountered, pertinent information and data and an analyses of findings. These reports are summarized for the FRAG and provide it an opportunity to redirect ineffective project activities. In addition to written reports, numerous telephone conversations between project directors and the FRMP staff determine interim progress providing opportunity for staff to render assistance in solving problems of an urgent nature.

Projects are site visited by FRMP staff at least semiannually, sometimes more frequently. These visits are cordial and are not viewed as a policing action. Honest sharing of information and exchange of ideas have led to innovative modifications and improvement in the conduct of project activities.

Feedback is provided to the various FRAG task forces, councils and committees in the form of semiannual progress reports on all operational projects. These reports are prepared by FRMP staff and are based on monthly reports filed by the project directors, site visits by the FRMP staff and correspondence or other communication with the principals involved in the conduct of the project activities. On occasion, a particular task force may request a project director to appear personally and report on his project. This opportunity is also provided to the FRAG and the FRMP Board of Directors. On several occasions, the FRAG and the Board have elected to invite project directors to attend one of their meetings to learn firsthand of the impact of FRMP programs on the health problems of Florida.

Similar information and data are furnished to the FRAG Planning Committee to assist their appraisal of progress in solving Florida's health care problems. Such information, based on the solving of problems and changing of needs, is used to update and revise priority areas of concern to the FRMP.

The flow of information is then directed to the FRAG Priorities and Evaluation Committee. This Committee, which reviewed the original project application, has the responsibility of judging whether the objectives originally proposed are indeed being accomplished through the project activities.

Decisions regarding allocations of funds among continuing and new projects are made by the FRAG's Priorities and Evaluation Committee. Input to this decision-making process is furnished in the form of staff analyses of project activities, reports and recommendations from the various FRAG task forces, councils and committees, and, on occasion, when the technical aspects of a project require special expertise, findings and recommendations of technical site visit teams or special consultants. Those projects which (1) show satisfactory progress toward accomplishing objectives, and (2) will assist the Program in meeting its overall objectives are recommended for continued funding. Funding recommendations are forwarded to the FRAG who, in consultation with the FRMP Board of Directors, may approve project continuation, redirection, or discontinuance.

A continuing concern of the FRAG, the FRMP staff and Board is that project directors diligently work toward developing new funding sources during the term of their project. In fulfilling its catalytic role, the FRMP endeavors to see that the activities initiated and refined during the project period be continued through support of the affiliated institutions or other funding sources.

This review process has enabled the FRMP in the relatively short period of its existence to address itself with considerable success to a wide variety of the state's health needs. Many of these activities are described in this special supplement to the Journal. Space does not permit a description of all 37 of FRMP's current projects and contracts.

Among the major activities of FRMP are those directed toward such important health service areas as:

A statewide Emergency Medical Service System.

A coordinated chronic dialysis and kidney transplant program.

An intensive care program for newborns aimed at reducing the 1,800 annual infant deaths.

A coronary care unit nurse training program that has prepared more than 500 nurses to serve in coronary care units.

A nurse-midwifery program aimed at reducing the 1,500 deliveries now done by lay midwives.

Consultation for family physicians in the care of children with cancer (3,200 consultations have been provided for 400 children).

Demonstration programs for the control of hospital-acquired infections.

Out-reach, "Health Guides" programs in three inner-city and a migrant labor area.

FRMP operates with a small staff and a minimum of overhead. All of the 37 projects are being carried out at a total annual cost equivalent to approximately 25 cents per capita based on FRMP's current funding level and Florida's population.

As this is written the national administration has declared its intention of phasing out regional medical programs and the President has included no funds for the programs in his fiscal 1974 budget year beginning July 1, 1973. Bills authorizing the

continuation of regional medical programs are now pending in the Congress so their ultimate fate is at the moment in doubt.

Without regard to what the future may bring, it is submitted that as a result of the cooperation and support of the physicians of Florida, the Florida Regional Medical Program has made a substantial impact on many major health problems and through the guidance of its Board, Advisory Group and expert committees, has used its funds wisely and effectively in aiding the solution of many of these problems.

► Dr. Larimore, 1 Davis Boulevard, Tampa 33606.

## Emergency Medical Services Program In Florida

WILLIAM T. HAECK, M.D. AND SPERO E. MOUTSATSOS, M.S.

Florida lacks a comprehensive system for providing Emergency Medical Services (EMS). In 1970 nearly 1,800 people died in Florida from automobile accidents.<sup>1</sup> During 1970, of the more than 40,000 people who died of heart disease in Florida, 65% died within the first hour of the onset of symptoms.<sup>2</sup> From national data, it may be predicted that approximately 12,000 of these people might have been saved if they had access to a good EMS System.<sup>3,4</sup>

Florida lacks adequate laws for the regulation of EMS on a statewide basis. State statutes require only 8½ hours of training for ambulance attendants. It is legal in Florida to transport the critically ill and injured with no attendant in the ambulance. Efforts to obtain adequate state legis-

lation on ambulance services failed in the 1970-71 and 1971-72 legislature. Efforts are being renewed for the current (1973) session. The present law calls for enforcement of the ordinance by the Florida State Division of Health and the county health departments. No state funds, however, have ever been appropriated to enforce the ordinance.

In 1969, with a modest allocation of federal funds from the Department of Transportation through the Governor's Highway Safety Commission, the Florida State Division of Health formally established a Section on Emergency Medical Services. The budget for the Section was \$43,000 during the 1972 fiscal year. This provided for secretarial staff, two EMS field representatives and some funds for education and training. The director of the Section was on loan to the Division of Health from the Division of Emergency Medical Health Services of the United States

Dr. Haeck is Director of the Emergency Medical Services Project, Division of Health, Jacksonville, and Mr. Moutsatsos is Assistant Director for Planning and Evaluation, Florida Regional Medical Program, Tampa.

Public Health Service, Department of Health, Education, and Welfare.

In 1970 and 1971, the Section conducted a county by county survey of EMS resources including equipment and facilities and advising counties and cities on the development of local programs. The 1970-71 survey revealed that comprehensive EMS programs, nationally recognized for their excellence, were operational in Jacksonville and Miami. A few other communities were identified as having promising programs underway or under development. However, the vast majority of the counties and larger cities did not have comprehensive programs, lacked satisfactory emergency vehicles and equipment, and had inadequate or poorly trained ambulance personnel.<sup>5</sup> Only a few counties and larger cities had plans on paper for EMS operations, but these essential services were usually given low priority.

### Statewide Plan

In the summer of 1971, the Florida Regional Medical Program (FRMP) reviewed priority health problems in Florida. In view of the lack of a comprehensive statewide EMS program, FRMP accorded the EMS problem a number one priority. Informal conferences were held with representatives of the State Division of Health, the state's medical schools, Florida Medical Association, Florida Hospital Association, and the existing EMS programs in Jacksonville and Miami. It was agreed that the Florida Regional Medical Program should develop a statewide plan to help improve emergency medical services to be operative within the Division of Health of the Department of Health and Rehabilitative Services of the State of Florida.

FRMP proceeded during the fall of 1971 to develop this plan. The medical literature was extensively reviewed; national authorities were consulted including those at the American Medical Association and the U. S. Department of Health, Education, and Welfare; successful programs in different cities and counties were visited; preliminary plans were reviewed by the state medical and hospital associations and the FRMP Committee on Health Services. The final plan was completed February 1, 1972, and approved as a cooperative enterprise between the Division of Health and the FRMP.<sup>6</sup>

Under this arrangement, the FRMP provides initial funds to the Division of Health for development and support of a statewide EMS program for a period of up to three years beginning

March 1, 1972. The FRMP also provides consultation and other support when indicated.

The Florida Division of Health maintains a central EMS office and facilities and provides the usual managerial and administrative services.

The central office functions in an administrative and leadership capacity directing the program's operations. Seven district offices staffed by FRMP district directors, and Division of Health EMS representatives are charged with implementing the EMS plan in their local areas. Implementation includes the development of regionalized services and formation of state, local and district emergency medical services advisory councils. These councils assist the staff in the formulation of program policies, as well as in planning and monitoring the ongoing program. In addition, some expert subcommittees of the state council have been established in such areas as legislation, finance, training, education, regionalization, communications, and priorities.

The joint program plan serves as the guide for both the central office and the seven district offices. A general administrative manual was developed which includes the policies and procedures to be followed by all personnel of the project.<sup>7</sup> In addition, a guide for the evaluation of the implementation of the project and its related activities was developed jointly by the EMS central office and the FRMP.

### Goals and Accomplishments

The long-range goal of the Florida EMS statewide project is to reduce mortality, morbidity and disability rates. Accomplishments thus far have stimulated the state and local government and the voluntary and professional organizations to become involved in the task of helping improve EMS for Florida citizens.

A state EMS council has been rejuvenated and work is underway to provide advice to the project in all phases of EMS. The council has also provided a forum of discussion and coordination for the many agencies with an interest in EMS. Among organizations represented on the council are:

FMA Committee on EMS; Florida Hospital Association; Florida Chapter, American College of Emergency Physicians; Trauma Committee of the Florida Chapter, American College of Surgeons; Florida Ambulance Association; Florida Chapter, Emergency Department Nurses Association; State Legislators; Florida Association of County Commissioners; Division of Communications; Division



of Health; Comprehensive Health Planning; Division of Planning, Department of Administration, and individual EMS leaders.

The cooperative efforts of the group have helped stimulate the Governor's interest in EMS. He has stated that one of the goals of his Administration is the improvement of EMS. To that end, a multiagency study group was convened and has prepared a preliminary 10-year state plan.<sup>6</sup>

This cooperative effort has also resulted in the preparation of companion House and Senate bills by Senator Poston and Representative Hodes. They are HB 124 and SB 127. If passed, these bills would:

1. Establish for the first time an official group within state government whose sole responsibility is EMS.
2. Establish standard training requirements for Florida's EMT's.
3. Establish recognized standards for EMS vehicles and equipment.

The proposed legislation is also tied to a budget request by the Department of HRS for \$1,000,000 to improve Florida EMS. Two additional bills have been prefiled. HB 447 would establish conditions under which state funds could be allocated to community EMS systems. SB 205 would allocate funding for planning EMS communication systems.

One outstanding effect of project activity has been to stimulate an increase in EMT training in the state. Over 1,000 EMT's will receive the standard 81-hour DOT course in 1973.

At the district level, activities have been concentrated on county and community EMS systems. Many EMS councils have been formed and are studying the needs of their service areas. In some cases, these councils have proceeded to the point of being able to formulate and implement effective local EMS systems. It is anticipated that the formation of local councils will continue and that eventually the entire state will have operative local advisory councils.

The project has also initiated studies to:

1. Define the educational needs of emergency department physicians and begin programs to meet these needs.
2. Define the educational needs of emergency

department nurses and begin programs to meet these needs.

3. Define the capabilities and needs of emergency departments in all areas of the state.

4. Define the retraining needs of Florida EMT's and begin programs to meet these needs.

There is no accurate tool to measure the impact of an effective EMS system. The project is attempting to locate the expertise and funding support necessary to build an appropriate tool. In addition to measuring the impact of new EMS systems, it is hoped the tool will be capable of delineating objectively any deficiencies in existing systems.

An accurate tool to measure the effectiveness of EMS training courses and to identify areas that need to be improved is also needed. This tool will be developed when funds can be located.

Accurate and easy access into the EMS system for Florida citizens is of paramount importance. Centralization of dispatch facilities and use of the the 911 System will be explored in more detail by project staff.

Effective telecommunications to link all elements of the EMS system are sorely needed. Efforts to detail exact needs for these communication links are underway.

Over 50 federal programs have authority to fund EMS activities. The project hopes to see that Florida receives its fair share of these funds. Present cutbacks in federal support of health programs are not clear enough at this writing to delineate the effect on federal EMS activities.

As local EMS systems improve, an effort will be made to identify regional health areas. Local systems will be encouraged to meld to effect regional EMS systems.

### Summary

The FRMP has funded, and given priority to, the development of an excellent EMS system for the citizens of Florida. The project has helped to unify the fragmented efforts of other groups in Florida in the EMS arena. Project activities are improving both local EMS systems and the status of EMS at the state level. Early evaluation of the project indicates that it will significantly help to stimulate Florida out of the EMS "dark ages."

References are available from the authors upon request.

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# Regional Medical Program of Hospital Infection Surveillance

N. JOEL EHRENKRANZ, M.D.

Hospital-acquired infection is a continuing problem of health care in the United States, which is likely to increase as new and sophisticated medical techniques are employed to deal with a variety of life-threatening diseases. Effective treatment of some cancers, heart and kidney diseases and cerebrovascular accidents may paradoxically increase infection. It is estimated that 50,000 to 70,000 Americans die annually as a result of hospital-associated infections—roughly the same number as die from automobile accidents. The cost of hospital-associated infections is estimated to exceed \$500 million per year. Thus, this is clearly an important problem in health care which has not disappeared with development of new antibiotics, vaccines and therapeutic devices. In fact, infections at times have occurred as a direct result of some of these therapeutic efforts. Moreover, hospital personnel including physicians and nurses may be exposed to other infectious diseases such as tuberculosis and hepatitis in the hospital setting—in some cases without being aware of the risk to themselves and their families. The diagnosis of tuberculosis or hepatitis may not be readily apparent in patients who are actively spreading infection.

The immediate goals of this Regional Medical Program of Hospital Infection Surveillance (Program #46) are the following: (a) To educate nurses, physicians, administrative and support personnel in criteria of hospital-associated infection and its recognition, and identification of patients and personnel at risk to hospital infection; (b) To examine conditions of hospital architecture, patient placement and use of various therapeutic devices that promote dissemination or acquisition of infection. The long range goal is to elevate the standards of hospital care so that infection is decreased or eliminated.

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## Training and Responsibility

The administration and staff of a group of hospitals in Dade and Broward Counties have made commitments for ongoing involvement and support of the program. Nurse-epidemiologists, physicians, administrators and other interested personnel from the participating hospitals attend weekly classes in the theory and practice of detection of hospital-associated infection and its prevention. Course work includes instruction in a standard approach to observing and recording rates of hospital-associated infection by organ site, infecting organism, geographic place of infection, professional service, patient risk factors, etc. This permits appropriate comparisons within a hospital or between hospitals. Formal course work covers mechanism of acquisition and spread of infection, analysis of published outbreaks, various strategies of prevention and measurements of efficacy. In addition to regular classwork, there is a weekly visit to each hospital by the physician-epidemiologist during which individual hospital problems are analyzed, including a review of procedures which are in force for prevention of infection, or limiting its spread. The potential for acquisition and dissemination of infection in various parts of the hospital is examined in great detail. The physician-epidemiologist is also available on short notice for on-the-scene investigation of outbreaks or review of episodes of hospital infection, and assistance in preparation of the monthly hospital infection committee report. He attends and participates in the monthly meetings of the hospital infection committee.

A number of specific areas has been examined in each of the participating hospitals. These include the type, cost and use of disinfectants; means and techniques for isolating infective and susceptible patients; flow of traffic within and between certain high risk areas; types of environ-



mental sanitation and ventilation; laboratory capabilities and limitations; employee health practices and awareness of types of hospital infection exposure of employees; type of infection reporting currently in use; discrepancy between reported and observed rates; use of various therapeutic devices known to be associated with spread of infection and efforts made to limit this to what is necessary for good patient care; responsibilities of the hospital infection committee; recommendations of this committee as a result of recognition of problems and examination of action taken.

Physician-epidemiologists each serve four or five hospitals on a regular basis. They review the records of patients considered by the nurse-epidemiologist to have had hospital-acquired infection to be sure the criteria for infection have been met. They review the results of environmental surveillance studies and aid in selection of sites to be studied. They analyze clusters of infection to seek a possible common source and thus try to detect at the outset an outbreak of infection or unusual predilection for disseminating microorganisms. They participate in review of antibiotic usage, antiseptic administration and related substances. They make rounds in the hospital seeking out unreported infections. To the extent possible, physician-epidemiologists render unbiased and consistent opinions. Their aims include elimination of serious hazards which may promote infection. These they seek out in cooperation with a hospital's nurse-epidemiologist and microbiologist. Once such hazards are detected, the responsibility of the physician-epidemiologist is to advise the hospital infection committee and the administration of the full implication of the hazard, so the committee can make informed decisions. Reportable infections of broad community importance are at times detected, and the physician-epidemiologists encourage prompt reporting of such infections to the county health department.

A computer program is currently being written for analysis of the data of the individual hospitals. This will provide each hospital with a detailed summary of its own rates of infection on a monthly and annual basis, along with comparisons with the other participating hospitals in a coded rank order, in order to preserve confidentiality. Hospitals that show significant departures from the mean infection levels of the group will be investigated as to cause, with a full report to the Hospital Infection Committee, including appropriate recommendations as to means for improvement.

## Broad Education Program

A further function is a broad educational program addressed to the community of health workers who are interested in hospital infection. Health workers including personnel from academic centers and public agencies are invited to attend the weekly classes given by the Miami based physician-epidemiologists—Dr. George Counts, Dr. Phineas Hyams and myself, and our chief infection control coordinator, Leilani Kicklighter, R.N. In addition, all are welcome at our annual seminar which is conducted by a faculty of national prominence. In the seminar concluded in January 1973 the faculty included: Miss Suzanne Legace, head nurse-epidemiologist from Ottawa General Hospital, Miss Elsie Buff of the Florida State Division of Health and Dr. George Jackson of the University of Illinois. A number of topics germane to hospital infection were explored in depth. These included techniques of surveillance of hospital infection, laboratory methods in detection of hepatitis, drugs and vaccines in influenza prevention, the need for antibiotic restriction and methods for evaluation of environmental contamination. These educational activities plus related publications have been made possible through the financial support of the Florida Regional Medical Program and the participating hospitals.

Finally, educational activities are carried out on a one-to-one basis when the need arises. It is obvious that each of the physician-epidemiologists has this as a prime role. In addition, individual consultation is available with Mrs. Kicklighter in matters dealing with nursing, and with Dr. George Counts in matters related to laboratory procedures.

We have been greatly encouraged by the enthusiasm of the staffs of the participating hospitals and by our first results in improving conditions leading to spread of hospital-associated infection. A number of new hospitals wish to join the group. We hope to be self-sustaining in another year. Our limiting factor in expansion is being able to provide adequate numbers of trained professional personnel.

In the largest sense, the program should be seen as involving more than infection. A consistently low rate of hospital-associated infection can be taken as one useful measure of the quality of health care. The ability to measure infection occurring in a hospital, in a reliable and reproducible way, and to decrease the episodes of hos-



pital-acquired infection along with unnecessary expenses for health care, are clearly desirable endpoints. We also feel these are attainable goals. Although hard and fast rules in individual cases may not always be applicable, it should be possible to define the actual rates of wound infection for various surgical procedures, pulmonary superinfection in the treatment of pneumonia, postpartum infection in obstetric conditions—to name a few common problems—and reduce these by improvement in the total care of the hospitalized patient.

In an era when patients with active tubercu-

losis enter general hospitals rather than sanatoriums, when hepatitis outbreaks occur repeatedly in hospitals, when ventilatory assistance machinery and intravenous fluids infect patients during the course of therapy, and persons with various life-threatening diseases such as lymphoma or renal failure are effectively treated with bone marrow suppressants, dialysis or organ transplantations, yet die from hospital-acquired microbes—control of hospital infection must be a major concern.

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## Florida Neonatal Intensive Care Program

RICHARD J. BOOTHBY, M.D.

The postnatal course of newborn infants varies from a minimum of asymptomatic adaptation to extrauterine existence requiring only observation and custodial care to a maximum of vital functions equivalent to the intensive care given a critically-ill adult. Thus, organization of facilities, staff and ancillary services can be divided into reasonably distinct groupings according to the care demands of the newborn population.

In bringing about the goal of promoting the intact survival of all infants (intact in this context implies that the infant will function as a complete human being, both physically and intellectually) born in Florida, the Florida Neonatal Intensive Care Program plans to demonstrate the effectiveness of a well-coordinated statewide system of newborn care that will reduce infant mortality and morbidity.

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### Operational Activities

Four major components are necessary to produce an effective newborn care program:

1. Identification of neonatal nurseries according to three levels of capabilities and assuring that they are properly staffed and equipped to meet newborn needs occurring in that particular nursery.
2. A communications system.
3. A transportation system.
4. An educational program.

### Details of Each of the Four Major Components

Nurseries will be classified according to capabilities and patient population at three levels:

1. Basic Newborn Nurseries.
2. Subregional Neonatal Centers.
3. Regional Neonatal Intensive Care Centers

A basic newborn nursery is one located in the smaller hospitals with capabilities for providing effective care to normal newborns and for stabilizing the newborn in distress before transfer to a subregional or regional center. The basic newborn nursery will care for infants of appropriate gestational age greater than 37 weeks who are asymptomatic. Table 1 lists the resources and capabilities of a basic newborn nursery.

TABLE 1.—BASIC NEWBORN NURSERY. RECOMMENDED RESOURCES AND CAPABILITIES.	
The Nursery	Housed separately from general pediatric care unit
The Personnel	A professional nurse is in charge of the nursery Twenty-four hour coverage is furnished by professional nurses or qualified licensed practical nurses Physician: Pediatrician or general practitioner on call
The Services Provided	Resuscitative measures Adequate airway Adequate suctioning Etc. X-ray services Basic laboratory studies Blood counts Blood chemistry Routine newborn care procedures Gavage Lavage Phototherapy Etc.
The Education Program	An ongoing planned in-service educational program

Subregional neonatal centers will properly care for newborns and mothers with medical and/or surgical problems. The subregional center will care for the following types of babies:

1. Appropriate gestational age greater than 37 weeks, asymptomatic.
2. Infants greater than 32 weeks gestation and weighing more than 1500 grams, growing and convalescent.
3. Infants greater than 32 weeks gestation, weighing more than 1500 grams, moderately ill.

Table 2 lists the resources and capabilities of a subregional center.

Since the majority of neonatal deaths occur in premature infants from high-risk pregnancies, regional neonatal intensive care centers will be identified to provide the specialized care required for such infants. The type of infant cared for in a regional intensive care center will be as follows:

1. Appropriate gestational age greater than 37 weeks, asymptomatic.

2. Infants greater than 32 weeks gestation, weighing more than 1500 grams, growing and convalescent.
3. Infants less than 32 weeks gestation, weighing less than 1500 grams (until stable), moderately and severely ill neonates, neonatal surgery, ventilatory support.

TABLE 2.—SUBREGIONAL CENTER. RECOMMENDED RESOURCES AND CAPABILITIES.

The Nursery	High-risk nursery is housed separately from regular newborn nursery
The Personnel	A pediatrician specializing in the care of newborns is in charge of the high-risk nursery A professional nurse is on duty at all times and may be assisted by qualified licensed practical nurses Consultation specialists available on call 24-hours a day X-ray Surgery
The Services Provided	All services available in a basic newborn nursery Oxygen therapy with automated monitoring Automated monitoring of vital signs T.P.R. B/P Fluid and electrolytes
Procedures as	Intravenous therapy including venous cut-downs Umbilical vessel (venous and arterial) catheterizations Spinal taps Inhalation therapy Exchange blood transfusions Mechanical ventilation
Additional laboratory studies	Bilirubin concentrations Blood gases Blood cultures
The Educational Program	An ongoing educational program for physicians and nurses

Tables 3 and 4 list the resources and capabilities of the regional neonatal intensive care center. The only major difference between the Type I and Type II center is the presence of a full-time neonatologist at the Type I. These centers will be strategically located throughout the state in existing facilities in Pensacola, Jacksonville, Gainesville, Tampa and Miami. Initially the centers will be located at Jackson Memorial Hospital, Miami; University Hospital, Jacksonville; Sacred Heart Hospital, Pensacola; Shands Teaching Hospital, Gainesville, and Tampa General Hospital, Tampa. Additional centers may be designated in other locations where adequate personnel and facilities now exist or as they are developed in the future.

TABLE 3.—TYPE 1—REGIONAL NEWBORN  
INTENSIVE CARE CENTER. RECOMMENDED  
RESOURCES AND CAPABILITIES.

The Nursery
An intensive care nursery separate from other newborn nurseries
The Personnel
Full-time pediatric staff
Full-time neonatologist
Pediatric house-staff: 24-hour coverage
Newborn intensive care professional nurse in the ratio of one professional nurse to no more than 2 infants: 24-hour coverage
Pediatric specialists in
Anesthesiology
Cardiology
Radiology
Pathology
Urology
General surgery
Cardiac-thoracic surgery
Neurosurgery
Specialists for consultation and service in
Neurology
Nephrology
Hematology
Orthopedics
Infectious disease
Endocrinology
Genetics
Plastic surgery
Transplantation
The Services Provided
All services available in a
Basic newborn nursery
Subregional center
All services provided by physicians listed under personnel
Critical care services of all types including
Complicated fluid and electrolytes
Complicated diagnostic problems
Cardiac surgery
Transplantation
Plastic surgery
Consultation services to subregional and basic newborn nursery physicians and nurses
The Educational Program
Provides ongoing in-service education for physicians and nurses within its facility and educational programs for subregional and basic newborn nursery personnel

### Communications System

It is essential that a communications network link the regional intensive care centers with the subregional centers and the basic newborn nurseries. Information essential to providing optimum care for each newborn must be communicated by the referring hospital to the receiving hospital. Another essential service is the need to provide consultant and guidance service to requesting physicians and nurses.

A communication system must be provided through which the referring physician at one nursery can easily contact the regional center for rapid initiation of patient transfer. We hope to accomplish this by means of the so-called "Hot Line" system. This is already in operation at the

University of Florida, and it is our plan to adapt this for the other regional centers in the state.

The communications system is essential in keeping parents and the infant's physician aware of the care their baby is receiving and his progress. If parents and referring physicians are not involved and do not have direct contact with the regional or subregional center, a concept of regionalized care will most probably fail.

Efforts will be made to tie into the statewide emergency medical services system communications network already in existence to avoid unnecessary duplication of equipment, personnel and expense.

Essential to facilitating the communications referral system is an adequate means of reporting and recording information. The system will need to provide standardized information and data regarding the status of a newborn upon transfer between centers, including diagnosis, treatment, patient outcome, follow-up information and care provided.

### Transport System

Safe, efficient transport systems will be established including ground and air capabilities.

TABLE 4.—TYPE 2—REGIONAL NEWBORN  
INTENSIVE CARE CENTER. RECOMMENDED  
RESOURCES AND CAPABILITIES.

The Nursery
Same as Type 1
The Personnel
Full-time pediatric staff
A neonatologist
Pediatric house-staff : 24-hour coverage
Newborn intensive care professional nurses in the ratio of one professional nurse to no more than 2 infants: 24-hour coverage
Physician specialists in pediatric
Anesthesiology
Cardiology
Radiology
Pathology
Urology
General surgery
Specialists for consultation and service in
Neurology
Nephrology
Hematology
Orthopedics
Infectious diseases
The Services Provided
All services available in a
Basic newborn nursery
Subregional center
All services provided by physicians listed under personnel
Critical care services of all types <i>except</i>
Cardiac surgery
Transplantation
Plastic surgery
Consultation services to subregional and basic newborn nursery physicians and nurses
The Educational Program
Same as Type 1



The level of medical care available to infants enroute should not increase morbidity or mortality as a result of the transfer. Experiences with several regional newborn systems in the United States and Canada have indicated that this goal is realistic and obtainable. Modifications will need to be made to meet the care needs of distressed infants such as the addition of portable incubators to existing ambulance equipment. Other services of the Florida Emergency Medical Services System can and will be utilized in transporting infants.

A newborn transport system can be structured either as an autonomous unit based in a hospital or it can be affiliated with an existing ambulance system. The first approach is exemplified by the ambulance service presently sponsored by the Pensacola Educational Program. Another type system is represented by the one operated out of the University of Florida and the one operating in Tampa. Jacksonville utilizes the Emergency Squad Ambulance System. In Gainesville these services include charter ambulance aircraft, while in Tampa it includes the capabilities of McDill Air Force Base Helicopter Services. In either system the essential requirements are availability and adaptability to the specialized needs of newborn intensive care. The transport vehicle must be readily available at all times, day or night, with a minimum alert period. A neonatologist and/or neonatology nurse-specialist should accompany the ambulance to pick up the newborn and provide care enroute.

### Educational Program

Development of an effective newborn intensive care system must involve the education of two major groups of individuals—health professionals and parents of high-risk and potential high-risk infants. The educational program for health professionals will include:

1. Updating the knowledge and skills of patient care provider teams (physicians, nurses, allied health personnel, hospital administrators) in all types of hospitals.
2. Developing physician-nurse teams to visit small hospitals to assist them in self-evaluation and to develop appropriate programs for their nursery staffs.

Educational programs for parents of high-risk and potential high-risk infants will include:

1. Informing parents of the purpose and value of different types of care facilities.

2. How these different facilities can provide the care the newborn may need or does need.
3. Situations requiring intensive care and why.

Knowledgeable, skilled and experienced physicians, nurses and other allied health personnel are essential to the success of any regional neonatal care system. They should be able to provide levels of care consistent with their resources and promptly recognize newborns with problems requiring transfer to more sophisticated centers and provide adequate care prior to transport.

Establishing and conducting regional education programs for physicians and nurses is an important and integral component of the program to reduce neonatal morbidity and mortality. Programs must be designed to meet the needs of those providing care to the newborn. Programs developed will utilize existing educational resources to augment the expertise presently available in existing intensive care nurseries. Curricula already available from the aforementioned regional neonatal intensive care centers will constitute a basis for developing the standard curricula for all courses initiated in the program.

### Program Organization

Bringing about a coordinated neonatal program to solve medical and surgical problems of the newborn required the appointment of a project director for the program and several advisory committees.

The main committee for the program is the Steering Committee, and it is comprised of members of the Fetus and Newborn Committee of the Florida Pediatric Society. Other members include an obstetrician, hospital administrator, the head nurses of the intensive care nurseries throughout the state and also public health physicians and nurses involved in newborn care.

Four basic subcommittees have been appointed by the Steering Committee: Curriculum Committee, Records and Reports Committee, Policies and Procedures Committee, and Evaluation Committee.

The project director is a physician on 25% time with expertise in neonatology. He functions as overall administrator of the program according to the advice of the Steering Committee.

The nurse associate project director is a nurse on 100% time with expertise in neonatal nursing. She assists the project director in carrying out his responsibilities. The nurse associate project director provides the leadership and coordination for the educational program for nurses,

physicians and allied health personnel. She actively participates in determining learning needs, formulating objectives, selecting content and learning experiences, setting up evaluation tools and restructuring the educational program as the need arises. She assists regional center faculties, organize and implement their programs.

A full-time secretary provides the required secretarial support to the project director and the associate director.

### Progress So Far

Since the program became a reality, both physically and financially about the middle of September, 1972, much groundwork has been covered. The project staff was appointed and an office established in Jacksonville. Committee members were appointed and the various committees were organized. It was decided it would be more feasible to geographically locate the various subcommittees; thus people who are in proximity to each other every day can get things done a lot better than particular subcommittee spread over the state. For this reason, the Curriculum Committee was established in Gainesville, Records and Reports Committee in Tampa, and a good percentage of the people involved in the Policies and Procedures Committee are from the Jacksonville area. It was clearly stated at the beginning, however, that this regionalization of the subcommittees did not and should not preclude feed-in to these committees from all areas of the state.

Once the committees were appointed and organized, the Curriculum Committee began its work of formulating the first nurse's course. During November, December and January the Committee worked diligently and this course is now underway at the various regional centers.

The Records and Reports Committee has been working equally as hard and has organized some of the statistical data that will be needed for the program and also certain forms needed to collect data.

Since the inception of the program, there have been five Steering Committee meetings and six such meetings are planned for the coming year. In addition, many members of the program have been meeting on a local level in order to implement the activities of the program.

### Goals for Remainder of This Year

Our goals for the remainder of this fiscal year include (1) conduct the course for nurses at least twice at each regional center; (2) hold one or two-day seminars for physicians at the regional centers; (3) have a nurse-doctor team visit basic newborn nurseries for the purpose of evaluating these nurseries and conducting a half-day seminar at each nursery; (4) identify at least 18 sub-regional centers by the end of August, 1973 and identify at least ten basic newborn nurseries by the same time with communications and transportation systems established between all of these hospitals and the regional centers.

### Summary

The Fetus and Newborn Committee of the Florida Pediatric Society, with support from Florida Regional Medical Program, has conducted a study and is developing a program to meet the needs of the high-risk infant in Florida. The program is based on a network of neonatal intensive care centers and extends through cooperative referral patterns and an educational program into each community hospital nursery. The Florida Regional Medical Program support is being provided through the Florida Medical Foundation for the implementation of the program which is under the direction of a project director. The main purpose of this program, as with others of its type throughout the United States and Canada, is to show that a reduction in neonatal mortality and morbidity can be accomplished by regionalization of newborn care.

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# Florida Renal Disease Program

WILLIAM W. PFAFF, M.D., BEN A. VANDERWERF, M.D., AND DON RIEDESEL

A number of community and university hospitals throughout the state have long had the capacity to take the first step in the definitive management of renal failure. They had the machines and knowledgeable physicians to lower blood concentrations of the end products of metabolism and to reduce circulating blood volume by removing water and electrolytes. Yet, until 1965, this approach was practiced sporadically, generally for the short-term care of individuals with either acute renal failure or in preparation to transfer to a medical center in another area of the country where dialysis and/or transplantation were being developed as a systematic approach to the solution of irreversible uremia.

In 1965, dialysis programs were organized in Gainesville, Miami and Tampa, for the continuing care of patients with renal failure. With the cooperation of uncertain administrators, machines and supplies were purchased and nursing personnel trained to care for patients on a daily basis, assuming many of the responsibilities in the conduct of dialysis.

As predicted by the nephrologists, for indeed they had observed the phenomenon many times in individuals with reversible renal failure, individuals with chronic uremia awoke from coma, their blood pressure became manageable, anabolic functions returned and, in some, return to normal occupation became possible. By this success, a new problem was created. The availability of dialysis to sustain life in patients with end-stage renal disease created a potential logistic night-

mare. In the main, individuals enter a medical system with a serious illness and are either cured, ameliorated to the point that they can leave the immediate confines of the system, or succumb to the disease. An individual with renal failure who is to be managed by dialysis in a hospital setting has a one year life expectancy of 85% and a five year life expectancy approaching 50%. He is dependent upon a machine, supplies and personnel, and the more successful the therapy, the more rapidly must all of these resources be multiplied.

This phenomenon was soon apparent at the University of Florida to the point that no new patients could be absorbed into the dialysis program pending other disposition of patients who had been enlisted earlier. In early 1966, the sole alternative was transplantation. With the aid and support of the combined clinical departments as well as several basic science groups, and with the cooperation of the hospital and medical school administration, a small transplant program was begun. Restrictions on the number of transplants to be performed were initially created by the participants, for at the time the long term results of transplantation were uncertain, the facilities available were limited, and the expense in dollars and effort were sizeable for the numbers of individual patients to be benefited. We chose to use cadaver donors, feeling that this should be the ultimate approach and the problems attached to this route needed solving. The participating personnel were untried and thus a potential living related donor should not be asked to donate a kidney under circumstances that were not truly optimal for success, both because of the state of knowledge then available and the inexperience of the group. Finally, it was concluded that the reported experience at that time could be im-

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proved upon to the point that cadaver organ grafting might yield results similar to those reported with living related donors.

In the ensuing four years, 32 transplants were performed at the University of Florida, all but one from cadaver donors. Our expectations were not entirely met however. The three year survival of transplants was 31%. Patient survival was 40%. In the spring of 1970, reassessment of means, alternatives and new options seemed appropriate.

In the interval, scattered transplants had been performed at other institutions in the state. In 1970, a more formal group was formed at the University of Miami that included all of the components that might be ideally required for the varied and vexing problems that occur with transplantation. This included transplantation surgeons who had prior experience in organ grafting, a tissue typing laboratory to identify ideal pairing of donors and recipients for both living related donor transplantation as well as cadaver transplantation, consulting services to provide expertise in infectious disease, pharmacology, special techniques in radiology, and the cooperation of nephrology services with an extensive experience in several approaches to dialysis.

#### Kidney Disease Program

In 1970, the Regional Medical Program bill was altered in the senate by an amendment, introduced by Senator Yarborough, which added kidney disease to the previously benighted categories of cancer, heart disease and stroke. Programs aimed at controlling renal failure thus became eligible for funding under this federal approach.

Interested physicians from the state gathered to assess existing resources and deficiencies and then, gathering under the umbrella of RMP, sought funds to correct the recognized insufficiencies.

The strength of the state's resources was an ever-increasing number of nephrologists who were locating in most of the major cities of the state, with near adequate capability for dialysis in Miami and environs. As noted, there were transplantation programs at the universities in Miami and Gainesville. Facilities for tissue typing were identified in Gainesville, Tampa and Miami.

The principal deficiencies were a markedly inadequate dialysis capability in northern and central portions of the state. Using what now ap-

pears to be a very conservative estimate of 40 patients with remedial disease per one million population, only a small fraction of relatively young adults and older children could be managed at the existing facilities in Tampa and Gainesville. Further, individuals were forced to travel some distance from other major population centers for twice or thrice a week dialysis. Once there, dialysis was limited to direct care in a hospital center. Home training facilities and personnel were not available. To digress at this point, home dialysis was being introduced at that time and is a practical means of reducing the costs and expanding the availability of patient management. The patient and a responsible relative are taught the techniques of dialysis, freeing personnel to repeat this task with succeeding patients in cycles of approximately six weeks. Ten to \$20 thousand savings can be appreciated on a patient-year basis. One of the major aims then of the physicians and the Regional Medical Program was to create new dialysis centers in Orlando, Jacksonville and Pensacola, each with emphasis on home training. In addition, home training programs would be added to the units at Tampa and Gainesville.

A second critical area was transplantation. As a grant request was being organized, written, revised and discussed, only 25 transplants were performed at the two centers in the calendar year 1971. At the University of Florida, these were predominantly living related donors and reflected the change in direction elected in mid-1970. Indeed, the survival statistics with living related donors are more encouraging. Graft survival for patients at risk for one year has been 79%. Using world registry tables for comparison, this would foretell long term survival in the 50%-60% range.

At the University of Miami, emphasis at the same time was on cadaver transplantation. When appropriate and available, living related donors are preferable however in both programs, considering the improved survival statistics, expectations, quality and duration of rehabilitation.

It was the purpose of the grant to increase transplantation numbers by subsidizing whatever ingredients were in short supply to deal with a larger load. This included faculty support, nursing personnel, technical assistance and administrative help to tie the diverse efforts together.

A third major area relates to organ procurement, tissue typing and organ sharing. Tissue

typing utilizes serologic techniques to recognize cell membrane antigens that are one determinant of graft acceptance. Within a family, tissue typing, or histocompatibility correlates exceedingly well with transplant survival. Among nonrelated individuals, the logistics, practicality and benefits of tissue typing are not as certain but remain to be determined by continued utilization. It was and remains our intent to transplant organs with the most favorable antigen matching. In addition to identification of shared antigens among potential combinants, the immunologist who conducts a typing laboratory also determines the presence or absence of antibodies against a potential donor, an event that precludes successful transplantation.

Tissue typing and cross-matching require time. Often, the donor, recipient and the typing laboratory are in separate areas. To preserve the kidneys until all ingredients are brought together, the RMP grant has provided for organ perfusion equipment, which allows preservation for up to 72 hours. This has the added advantage in predicting viability when the nature of perfusion in antecedent terminal illness or injury may have produced irremedial damage.

Perhaps the most difficult and rate-limiting task common to all of the participants in the state program is the identification of adequate numbers of cadaveric kidney donors. Many patients with end-stage renal disease simply do not have an appropriate living related donor and the only potential alternative is thus a nonliving unrelated donor. Enlistment of the aid of physicians throughout the state is sought to give notification when individuals, particularly with mortal neurologic injury, might be used as kidney donors. The participating nephrologists and transplantation groups have repeatedly stressed their willingness to cooperate in clarifying the criteria under which a potential donor might be used and the steps to be followed in bringing about such a donation. Recent passage of the Uniform Anatomic Gift Act by the Florida legislature will surely ease this task over the years as larger numbers of our population participate in an elective program.

A number of other activities were proposed within the grant and certainly would be required to earn the adjective "comprehensive" that was initially used to designate the program. This in-

cluded screening programs, physician and public education and the production of antilymphocyte globulin, an immunosuppressive agent of some significant potential use in transplantation. The disallowance of the latter was on the basis of its still experimental nature.

Perhaps one of the more unique features of the RMP grant was co-funding of the administrative apparatus with the State of Florida, relying on a legislative appropriation that created the Florida Kidney Disease Board. Responsibility for administration was assigned to the Department of Health and Rehabilitative Services, and between the state and Florida Regional Medical Program administrations a coordinator was hired to link the activities of the federally financed grant. Abetted by additional financing from the state legislature, the efforts of physicians, scientists, nurses, technicians and volunteers in the state and private universities, community hospitals, county hospitals and independent dialysis units were combined to solve a medical problem that demanded effort, organization and funding.

Six months after the initiation of the RMP grant, the initial goals have been met. New dialysis units are in operation in Orlando, Pensacola and Jacksonville. The rate of transplantation has roughly tripled, and anticipated transplants within the state in the first year of the grant should total 60-75 grafts. The typing laboratories are using uniform techniques. Organ preservation equipment has been used and found workable. Kidneys have been transported from center to center, implanted and found to function. In short, the purposes for which we gathered are being met.

When a statewide program was envisioned, only a fraction of the individuals with renal failure were being recognized, a smaller fraction had dialysis and transplantation available to them. Physicians conducting such programs faced the unwholesome task of denying or postponing procedures that would give both comfort and life. The primary intent of the Florida Renal Disease Program was to ensure care, through dialysis and/or transplantation to any individual with end-stage renal disease. It would now appear certain that the goal can be achieved.

► Dr. Pfaff, Department of Surgery, University of Florida College of Medicine, Gainesville 32601.



# Continuing Medical Education

MICHAEL J. PICKERING, M.D.

In May 1972 the House of Delegates of the Florida Medical Association voted to require a minimum of 30 hours of continuing education to become effective January 1974. The Committee on Continuing Medical Education was charged with developing the mechanism to implement those requirements. The final drafting has been done.

In the process of developing this document, many questions arose. What type, or types, of educational opportunities are best in producing a change in the behavior of the recipients? What educational needs are there in this state, the area or the community? How best is quality education made available to all physicians? There are many more such questions, but if answers to just these three could be found, great strides in continuing education for the Florida physician could be taken.

Attempting to solve the first question we were faced with little data. Internal evaluation of medical education is of rare vintage. Evaluation of continuing education opportunities is more of a rarity. Such statistics as members that attend or the number of times attended are of no help in determining if that attendance changed or upgraded the practice of the individual. The methods tried previously are each stated to be of value to some. Perusal of the literature has become practically prohibitive. Which of the voluminous articles are fact, fancy or fruitless? To attempt to stay current in a subspecialty in this manner is a Herculean task often not accomplished. Whether these change the practice of the reader is unknown.

Didactic seminars and meetings have been of

suspect value as continuing education for quite some time. Transferring the notes of the speaker to the note pad of the listener is usually a practice in speedwriting. How much is retained, or more importantly, used, is unknown.

Self-evaluation tests have recently been touted as a rewarding endeavor. At least the student has to do some of the work which, according to Sir George Pickering, is required for education. Does the successful completion of such work provide the stimulant and the ability to alter individual patient care?

There is no answer to the question, "What are the needs?" We have not had the mechanism to determine the needs at the point of contact with the patient, and only through this data can one find the remedy that is pertinent.

Pondering the last query leads one to the conclusion that the first two questions must be answered to provide adequate groundwork upon which to make rational decisions.

It is with these thoughts in mind that the Committee on Continuing Medical Education began looking for available mechanisms to provide the opportunity to gather the necessary facts. Ideally, one could gather the proper data by instituting educational opportunities of various types based on established data of needs, containing intrinsic internal evaluation that would be uniform. The FRMP with its functioning district offices, monies for initiating projects and expert advisors offers an excellent chance for a cooperative venture. Preliminary discussions have pointed to excellent cooperation and an exciting chance to gain real facts and thereby provide the patient proof that the physician is constantly attempting to provide him excellence in medical care.

► Dr. Pickering, 1600 Lakeland Hills Boulevard, Lakeland 33801.

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Dr. Pickering is Chairman of the Committee on Continuing Medical Education, Florida Medical Association.



# Comment

ROBERT P. LAWTON

Dr. Pickering's statement accurately raises the specific questions and problems which bear on implementation of the FMA's program of a required minimum 30 hours of continuing education. The Florida Regional Medical Program has the capacity and the desire to assist with the answers to those questions, solution of those problems and general implementation of the FMA continuing education program.

PSRO, peer review, quality assurance and continuing education are all interrelated and have as their common mission continued improvement of the care of the patient through increases in the knowledge and skills of the physicians. The selection of the seminar, course, conference or article which will be of greatest relevance and value to the individual physician and hence to his patients will be determined by constructive peer review of the effectiveness of care. As Dr. Pickering states, some assessment of the impact of continuing education on the physician's practice and on the quality of care received by his patients is necessary and the knowledge that it brings about demonstrable change for the better is essential. Further, it is crucial to the preservation of the system of self-regulation by the profession.

The following may well be the prime principles of a program:

1. Continuing education programs should be related to the major health problems of the people of Florida.

2. Selection of programs, and curriculum de-

signed for new programs, should have major input from practitioners.

3. There should be a major, coordinated segment of program from the three medical schools, with appropriate compensation.

4. New techniques to bring continuing education to busy and/or isolated practitioners in their own practice settings should be devised, tested and implemented.

5. A central registry of accredited programs should be maintained.

6. There should be a central data bank to report the accumulated hourly totals of accredited continuing education for each FMA member.

7. There is widespread agreement that the cost of continuing education programs for physicians will be met by them.

There should be a compact, among the organizations and institutions concerned, pledging a concerted effort to coordinate and rationalize Florida's future system of continuing education for physicians, to implement the principles cited and, in effect, make positive response to Dr. Pickering's questions.

FRMP is drafting such a compact for consideration by the institutions and associations involved. If it continues to receive operational support, FRMP is prepared also to be responsible for the development and maintenance of a total, long range program and generally to work in the closest concert with the FMA.

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# Coronary Care Unit Training Program

LOUIS LEMBERG, M.D., AND AZUCENA G. ARCEBAL, M.D.

The introduction of coronary care units (CCU) in the management of acute myocardial infarction has been recognized as one of the most important contributions to medical progress in the last decade. Through intensive monitoring of the patient with acute myocardial infarction, the early recognition and prompt therapy of potentially lethal derangements of heart rhythm have significantly and favorably altered morbidity and mortality. Since the advent of coronary care units hospital mortality from acute myocardial infarction has dropped from 33% to as low as 12%.

Reports indicate that the number of deaths from coronary heart disease in the State of Florida continued to rise from 1950 to 1966. This trend relates to the increasing number of Floridians in their 6th and 7th decade of life. Although a few hospital centers, mainly in the cities, had initiated one to two-week nurse training courses in coronary care and established coronary care units, there were rural areas of the state without facilities for this specialized care of patients. A major factor was the lack of trained nurses, as well as medical personnel to man such units.

In the hope of bringing this special type of medical care to the people in the smaller communities, a comprehensive coronary care training program was conceived for four teaching medical centers of the state. Since the keystone of success is a well trained and motivated nursing staff the course was made available only to qualified nurses.

## Courses for Nurses

Through the Florida Heart Association (FHA) and the Florida Regional Medical Program (FRMP), 4-week courses were started in March 1969. The immediate and long-term results were judged to be excellent. Every course included fundamentals of cardiac nursing, basic sciences (anatomy and physiology of the cardiovascular system), electrophysiology and electrocardiography, pharmacology of cardiac drugs, cardiopulmonary resuscitation and the use of specialized electrical equipment for monitoring and treatment of cardiac emergencies.

The Florida Heart Association's Professional Education Committee with its previous two year experience in training nurses for coronary care was able to expand its role in coordinating courses of instruction in coronary care and provide a 4-week course with the help and cooperation of the FRMP. The role of the FRMP in this combined endeavor was significant and decisive in the success of the program.

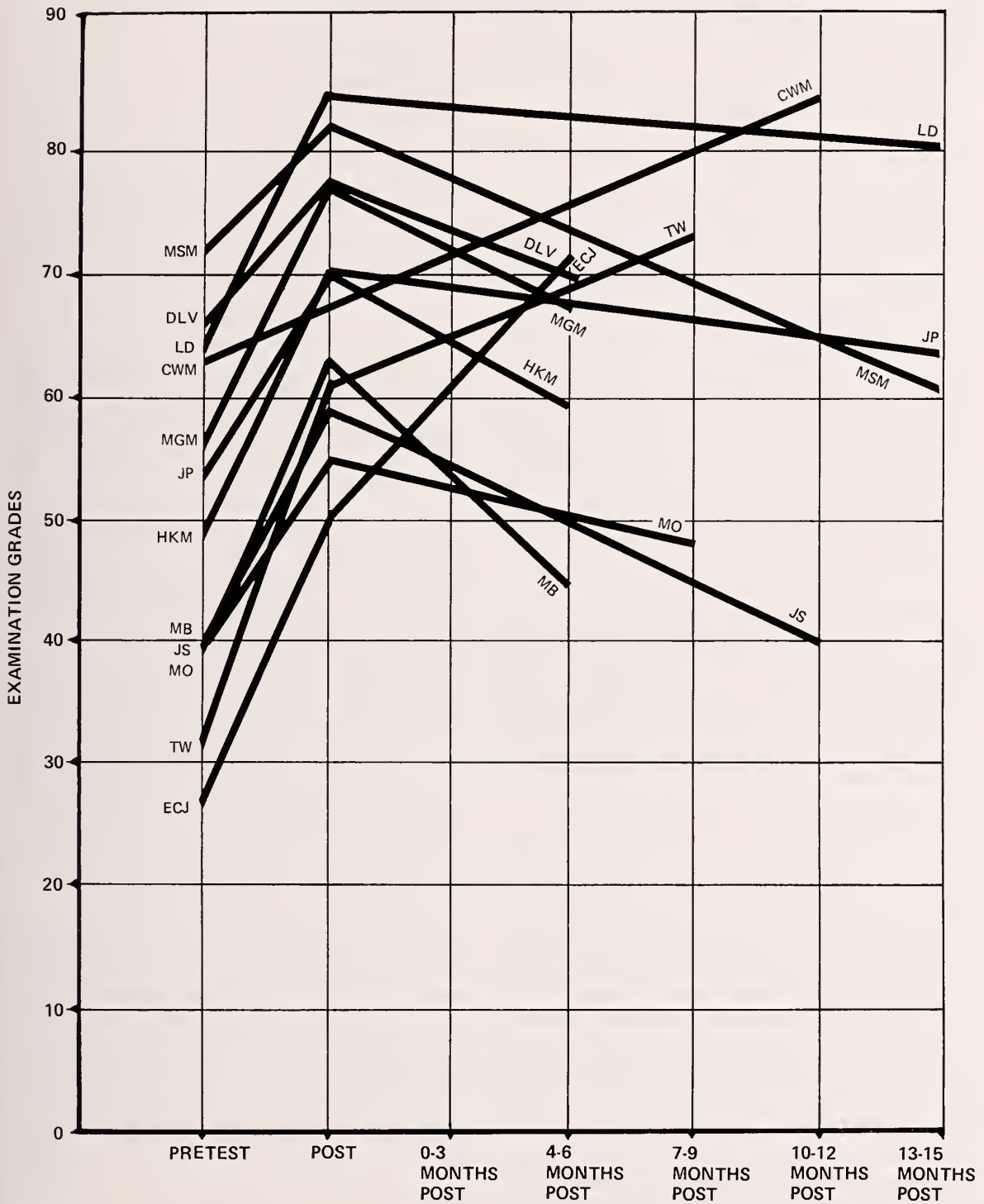
During the three year operation of this project 31 courses were given in Florida with RMP support and coordinated by FHA. Four hundred and seventy-five nurses completed the courses. In addition two multicounty courses were given and 18 nurses were graduated. As was done in the other three teaching centers, uniform pretests were given to each student at the onset of the course, with the objective of evaluating the level of knowledge of each nurse and helping identify future needs of the program. Besides formal lectures, ECG practices and clinical bedside rounds with the medical staff of the CCU, an examination was given at the end of each week in order to test the student's ability in applying the material learned during the preceding week to patient situations.

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FIGURE 1



Graph illustrating pre and post-testing scores. These are compared to the second post-test score given four to 12 months after completion of the CCU course. Note that two physicians showed an improved score in the last post-test.



At the completion of each course, a post-test was given in order to evaluate the level of knowledge attained and how this knowledge was applied in clinical situations. This was not considered to guarantee how well a nurse would function in a CCU but did serve as a measure of her newly acquired capabilities.

Following the completion of the course, these nurses were either employed in a CCU, participated in, or initiated training courses in coronary care in their areas. Many were instrumental in establishing coronary care units in their hospitals.

As an outgrowth of this program of CCU nurses training, courses in other fields of intensive medical and surgical care have emerged. In addition a number of manuscripts have been written by CCU nurses graduating from this program and these have been published in national journals. More recently a textbook in programmed instruction in coronary care has been published by nurses who had completed the program and subsequently became instructors. All of these are evidence of the stimulus this program had on its participants.

#### Courses for Physicians

A series of courses of instruction in coronary care for the practicing physician were initiated in September 1970. The program was designed to provide close teacher-student relationship to insure comprehensive training and thus the courses were limited to four physicians per session. Priority was given to the general practitioner from small communities in Florida.

The physicians' course consisted of six days of comprehensive lectures and coronary care training with emphasis upon the practical aspects of diagnosis and care of patients with acute myocardial infarction. The days were divided into ten hours of instruction which included two hours each morning of clinical bedside rounds in the CCU and 14 hours "on-call" during the night for problems arising in the CCU. As often as possible, the physician-student was exposed to practical demonstrations of techniques such as cut-downs, insertion of central venous pressure catheters, flow diverted pulmonary artery catheters and arterial needles, pacemakers and cardioversion. Current concepts in the treatment of

myocardial infarction, especially arrhythmias, were emphasized as well as applied electrocardiography, electronic monitoring, and CCU planning and administration.

A list of suggested reading material, together with a pretest was mailed to each physician-student accepted into the program. This served to evaluate the level of knowledge in cardiovascular medicine prior to the course. A post-test was given on the last day of the session. The main objective was to reemphasize points of clinical importance to the practicing physician. During the 16-month program 20 courses were given and 81 Florida physicians were trained.

#### Postgraduate Seminar

Fourteen months after the first course was given, a one-day postgraduate seminar was held at Jackson Memorial Hospital, Miami. Twelve physicians who had completed the course four to 12 months earlier attended. At the onset of the seminar the physicians were asked to take the same post-test that had been given to them during their CCU training. The order of questions was changed in order to eliminate the possibility of rote memory. The results (Fig. 1) showed that although the majority obtained more or less the same score a few made higher grades. This was gratifying since it was apparent that the retention level was high considering the length of time elapsed. A number of physicians were responsible for setting up CCUs in their local hospitals and also initiating coronary care classes for nurses and other physicians. Some have arranged programs for interesting cases or ECG's. All of these added dividends of this training program attest to its success.

Both the nurses and the physicians courses initially supported by FRMP are being continued on a self-support basis. This is in true keeping of RMP philosophy which was to help initiate and financially support local programs aimed at improving the health of the public primarily through physician or paramedical education and these programs if successful and well established would subsequently be continued on a local self-support basis.

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# Intensive In-Service Education for Physicians

ARVEY I. ROGERS, M.D. AND SIDNEY BLUMENTHAL, M.D.

For many physicians, a highly desirable form of continuing medical education is an activity designed to fulfill identifiable needs, oriented around specific, well-defined objectives, and presented intensively in an educational atmosphere, preferably removed from daily work responsibilities. These features formed the basis for the "Intensive In-Service Postgraduate Education for Physicians" activity which has taken place at the University of Miami School of Medicine over the past two years. The program was sponsored by the Florida Regional Medical Program and coordinated through the Office of the Division of Continuing Education at the medical school. The following information is provided to summarize major aspects of this activity.

Basically, brochures mailed throughout Florida announced the program, described objectives, course offerings, and facilities. Interested applicants requested (1st year of mailing) or completed (2nd year of mailing) an application in which specific needs were solicited. If a program was available at the medical school, an appropriate faculty member was selected, the application discussed with him, and the request made that he review the application with a view toward possibly accepting the applicant. Frequently, personal phone calls between preceptor and preceptee ascertained more specifically preceptee needs and preceptor capabilities at the time. This "personal" approach was encouraged, as it provided an opportunity for meaningful communication between student and teacher at an early stage of program design. If agreement was reached, arrangements for specific time period were made; if none was reached, another faculty member was sought. Processing usually took 4-6 weeks. The Division

of Continuing Education coordinated all administrative arrangements pertinent to the trainee's use of medical center facilities and involvement in aspects of patient care. Total cost to the trainee included travel and living expenses as well as those related to leaving a practice for 1-2 weeks; no tuition was charged. With rare exception, trainees felt the experience worth the expense and indicated a willingness to provide a tuition if this became policy in the future.

Tables 1-5 present demographic data related to the 88 enrollments (85 physicians) in the intensive in-service activity. Slightly less than one half participated in programs devoted to cardiovascular and neurological diseases. Fifty-one of the registrants represented the major disciplines of family practice, internal medicine and pediatrics. Physicians tended to come from Dade and Broward Counties (33 of the 85), but 17 total counties were represented. Of the 72 physicians in which ages were known, 42 were between 41 and 55 years of age. Fifty-six had been in practice more than seven years; 46 had been practicing more than ten years. This is gratifying in view of the observation that the half-time for retention of medical knowledge is estimated to be between five and seven years. Of some interest is the appeal the program had for doctors of osteopathy; while less than 10% of Florida's physicians are represented by this group, 17 or 23% of the 88 physicians participating were D.O.'s.

A total of 233 applications were submitted for possible course enrollment. For a variety of reasons, all except 88 enrollments were not completed. The usual reasons were the inability to accommodate the "broad" requests of the individual seeking the educational experience; inability of the individual to narrow his needs to those which had the greatest chance of fulfillment within 1-2 weeks; program not being offered at the medical school; "personal" reasons. Further comment on several of these is appropriate. Many applicants expressed the view that they wanted to

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TABLE 1.—PHYSICIAN ENROLLMENT.

Total Enrolled:	88	(represents 85 individual physicians; 3 re-enrolled)
M.D.	71	
D.O.	17	
Total Course Hours Completed:	4,351	
Age Distribution of Enrollees:		
25-30	1	
30-35	6	
36-40	12	
41-45	13	
46-50	16	
51-55	13	
56-60	5	
61-65	3	
Over 65	3	
Unknown	16	
	88	

TABLE 2.—LENGTH OF PRACTICE OF ENROLLED PHYSICIANS.

YEARS	NUMBER OF PHYSICIANS
0- 1	5
1- 3	4
3- 5	10
5- 7	4
7-10	10
10-15	11
15-20	13
20+	22
Unknown	9
	88

TABLE 3.—COUNTY DISTRIBUTION OF ENROLLED PHYSICIANS.

Broward	15
Charlotte	1
Dade	18
Duval	3
Escambia	3
Hillsborough	6
Indian River	2
Lake	1
Lee	3
Monroe	1
Okaloosa	1
Orange	8
Palm Beach	7
Pinellas	5
Polk	4
Sarasota	1
Volusia	8
Out-of-state	1
	88

TABLE 4.—PRACTICE SPECIALTY OF ENROLLED PHYSICIANS.

Angiology	1
Anesthesiology	5
Cardiovascular Disease	3
Dermatology	1
Family Medicine	5
Emergency Medicine	2
General Practice	18
General Surgery	2
Internal Medicine	14
Neurology	1
Neurosurgery	1
Ophthalmology	11
Orthopedic Surgery	1
Otolaryngology	1
Pediatrics	11
Physical Medicine & Rehabilitation	1
Psychiatry	4
Radiology	3
Urology	4
Unspecified	2
	88

TABLE 5.—MEDICAL SPECIALTIES IN WHICH PHYSICIANS WERE ENROLLED.

Anesthesiology	6
Cardiovascular Disease	24
Dermatology	1
Endocrinology	3
Family Medicine	1
Gastroenterology	1
Neurology	18
Ob-Gyn	1
Ophthalmology	11
Otolaryngology	2
Pediatrics	11
Psychiatry	1
Pulmonary Disease	3
Radiology	3
Renal Disease	1
Urology	1
	88

get the most for the time and money spent; this was translated to mean that they preferred to review an entire specialty rather than a specific area of that specialty. An individual who desired to learn something about the EKG interpretation of cardiac arrhythmias was more likely to feel that his needs were met by program design than the individual who wanted to "review cardiology." Previous experiences in this approach to continu-



ing education had emphasized the importance of recognizing needs as the basis for realistic program design which offered the best chance to meet needs within the week's period of intensive study set aside. Every effort was made to adhere to this educational objective. We recognize that there are certain shortcomings when program design is based on a physician's subjective assessment of his needs; often, there is no parallel between expressed and objectively assessed needs. The objective assessment of physicians' needs as they relate to patient care is difficult, utilizing tools presently available to educators. Meaningful parameters for doing so will ultimately evolve.

The program was evaluated by questionnaire which attempted to elicit and compare faculty (preceptor) and enrollee (preceptee) responses to nearly identical questions. Questions concerned whether goals were attained, extent to which needs were met, educational tools utilized in the process, amount of time devoted to specific instruction as compared to self-instruction, whether the individuals would participate in similar undertakings in the future, etc. In general, there was agreement and affirmation. Major problem areas related to difficulty in determining specific needs and designing "personal" programs to fulfill the needs. The enrollees were asked whether they felt the experience improved their ability to take care of patients; with rare exception, the response was affirmative. Objective evaluations were not undertaken.

Continuing medical education is a complex process, involving teaching and learning. It is complicated by the many variables relating to methods and evaluation parameters applied to who teaches what, to whom, when, in what form, and for what purpose(s). The very complexity of the process has encouraged useful experimentation; newer methods have evolved. Increasing emphasis on the process of evaluation has forced a closer look at overall objectives, methods, and results. The truly accurate assessment of continuing medical education program effectiveness depends to a great extent on the ability to measure its effect on the overall objectives, methods and results. The truly accurate assessment of continuing medical education program effectiveness depends to a great extent on the ability to measure its effect on the overall quality of patient care. Sustained high quality or improvement in the quality of patient care is an acceptable goal of the continuing medical education process; though probably attained frequently, it is difficult to measure, since "quality" and "patient care" are not easy to define. Evaluation of the process of continuing medical education must await the evolution of an equally complex process, that of the establishment of criteria for quality patient care. The primacy of activities related to establishing such criteria, which must be relevant and sensible, is obvious.

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# New Scalar Computer EKG Program for On-Line Central EKG Processing

LAMAR E. CREVASSE, M.D. AND MARIO ARIET, PH.D.

When one considers that nearly 100 million electrocardiograms are processed in this country each year the problem of their systematic analysis, storage, and retrieval is of considerable magnitude. The ever-increasing demands on the health care system for efficiency, cost control, and responsiveness make computers ideal for handling this type of medical data. The speed, accuracy, memory, and logic of the computer provides an excellent system for EKG analysis. The computer furthermore has a capability of handling large volumes of electrocardiograms with rapid turn-around.

A computerized EKG center must provide the necessary service for outlying hospitals with a responsive turn-around system which can return the electrocardiogram to the sending site within a few minutes. The responsiveness of this system is essential for emergency rooms, preoperative evaluation, and many other situations.

It is now possible with the new EKG programs to have a responsive system which is capable of acquiring, analyzing, and returning the EKG analysis to the sending site within three minutes with an accuracy that is comparable to that of physicians with the exception of complicated rhythm disturbances.

## Systems

The regional computer EKG system as outlined here is located at the University of Florida College of Medicine in Gainesville and was funded through the Florida Regional Medical Program. It is designed for the acquisition, multi-lead transmission, reception, and recording of electrocardiographic signals from throughout

Florida. The total system consists of data acquisition carts, data transmission phones, and a sequential telephone answering interface which receives both local, WATS line, and emergency calls on a priority basis with tape recorder backup systems. The signals are received by a telephone receiving interface and fed directly into an IBM 1800 computer through an analogue to digital converter. The program analyzes the twelve-lead electrocardiogram<sup>1</sup> and the Frank vector system.<sup>2</sup> For the University and certain larger hospitals Frank lead vector plots are made available on all abnormal EKG's.

A telecommunication system automatically dials the sending hospital's teletype and returns the scalar analysis to the sending hospital within a three-minute period. The analysis time for both the scalar and vector system is approximately 60 seconds. We are currently processing EKG's from ten community hospitals, the University and VA hospitals, and several smaller clinics throughout the state.

## Data Acquisition

Our EKG patient transmitter carts® acquire all of the standard twelve leads, three leads simultaneously for six seconds each, and 12 seconds for the Frank XYZ system. In dialing the computer with its sequential telephone priority answering service the call holds until the technician receives an answer signal from the computer. The EKG identification and transmission is now sent directly into our computer with analogue magnetic tape backup. We have a three-channel direct writer in the computer center for monitoring all EKG's or technical problems. In addition, a technical program for noise, missing interrupts, or measurement inconsistencies teletype back the failure of EKG acquisition and analysis. In addition, it signals the sending cart with three audiovisual signals

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This work is supported by Florida Regional Medical Program Project #3.

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that the tracing is unsatisfactory and to repeat. If the tracing is satisfactory, an audiovisual signal so informs the technician.

Computer Programs

A variety of computer programs are available and the major deterrent to the growth and acceptability of computer EKG analysis has been the lack of an EKG program with the reliability and consistency in any way comparable to physician analysis.

The previous first versions of various programs have been evaluated by a variety of groups and are not satisfactory for on-line turn-around without over-read.<sup>3</sup> The occurrence of a high incidence of both false positive and false negatives require constant overview by a cardiologist. A perfect EKG program is obviously unlikely because of the multiple variables related to transmission, noise, faculty program logic, and electrocardiographic variations. However, a new EKG program and system with reasonable clinical correlation is now available for the routine analysis of electrocardiograms.<sup>1</sup>

Data acquisition, EKG transmission, and computer capability are currently functioning in an efficient manner in a variety of settings.<sup>4</sup> We have evaluated and refined this program in the University and affiliated VA hospital system utilizing it to service the needs of the regional hospitals and clinics. We have recently implemented the new scalar EKG program and have done a detailed test on a University hospital population of 1,000 consecutive EKG's with clinical interpretation read by two or more physicians and compared in retrospect with the computer EKG analysis. The computer exhibits a high degree of resolution in being able to differentiate normal from abnormal with 97% reliability. The overall computer contour statement accuracy is comparable to the 92% physician accuracy statements correctly stated. The false positives and false negatives are comparable and are related primarily to physician and computer logic criteria employed. The major flaw in our computer EKG programs is the inability to analyze complex arrhythmias such as AV dissociation, supraventricular tachycardia, varying block, multiple ectopic foci, or other complex arrhythmias. The program, however, states

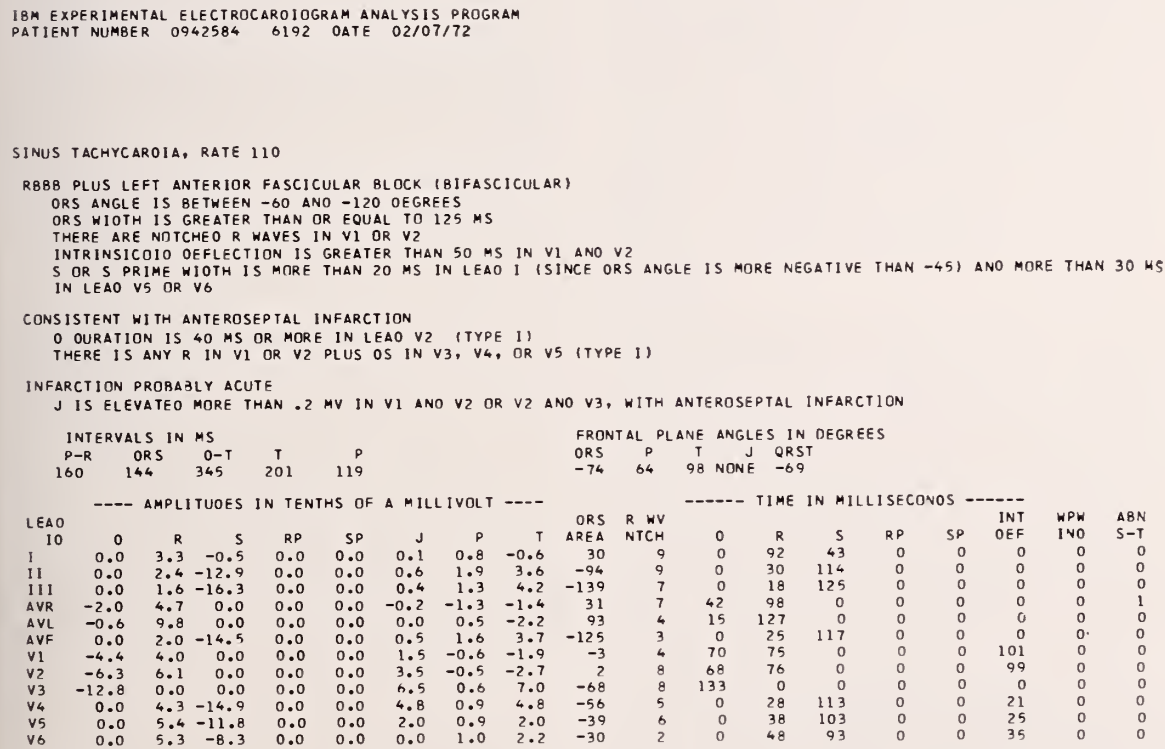


Figure 1



undetermined rhythm, and these rhythms are then examined clinically at the center. We believe this new scalar EKG program with a 92% overall contour statement accuracy performs comparable to physicians in contour analysis in routine electrocardiographic diagnosis. It has a low percentage of false positive and false negative statements. We are comfortable with its reliability to turn-around a reasonable answer for community hospitals providing an efficient economical system for electrocardiographic analysis.

In each of our contour statements the logic criteria is printed to indicate how the computer arrived at that specific diagnosis. We feel this is an important quality control mechanism as well as an educational vehicle for physicians interested in electrocardiography. A selected electrocardiogram and printout is illustrated in Figures 1 and 2.

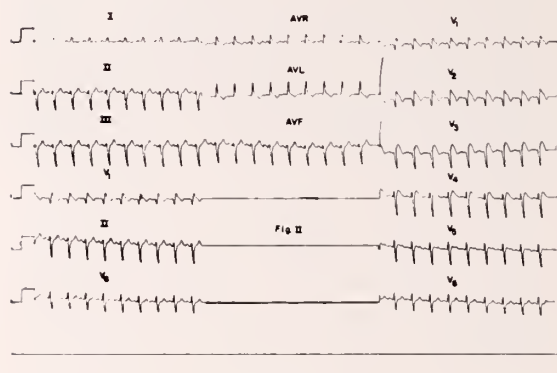


Figure 2

## Summary

A regional computerized EKG processing center now provides automated efficiency for on-line analysis of electrocardiograms to a broad spectrum of hospitals and clinics throughout the state initiated by the Florida Regional Medical Program. It brings reasonable expertise in electrocardiographic assisted analysis to areas with and without cardiologists. It assists the cardiologist and physicians without cardiovascular expertise in measurements and contour suggestions. It provides an educational mechanism for physicians through statement of criteria used for each contour statement. Computer assisted analysis at this time provides an economic and rapid mechanism for analysis of the electrocardiogram and assists the physician in EKG diagnosis. However, the clinical judgment of a physician must prevail in relating the computer assisted analysis to the proper clinical situation.

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► Dr. Crevasse, Department of Medicine, University of Florida College of Medicine, Gainesville 32601.

# Cervical Cytology Revisited

JAMES E. FULGHUM, M.D. AND JOHN C. REAGAN, M.P.H.

Cervical cancer claimed the lives of an estimated 258 Florida women during 1972 and another 220 died from cancer of other parts of the uterus. These are, for the most part, preventable deaths. The lives of many are being saved through early detection by the Papanicolaou (Pap) test, a highly accurate, inexpensive and painless test for cancer of the uterine cervix.

## Mortality

In Florida, as in the nation, early detection and adequate treatment have been responsible for a reduction in the number of women dying of uterine cancer during the past two decades. Figure 1 shows the death rate of Florida women from cervical cancer by race for 1960-1971. This shows that the mortality rate can be and has been favorably influenced.

A slight increase in the death rate among black females is noted for the year 1971; however, this does not offset the general downward trend of total uterine cancer deaths.

The mortality rate for both white and total has shown a downward trend with a 48% decline in the rate for white women in the past 11 years. Figure 2 shows death rate for cervical cancer among Florida females by age group for the years 1960, 1965 and 1970. There has been a remarkable decline in all age groups for the years 1965 and 1970, as compared with the year 1960. The age group of 65 and over has, however, shown the least amount of decline. Figure 3 shows the percent distribution of deaths of Florida women from cervical cancer by age during 1960, 1965 and 1970. This reveals that in 1970 over 40% of the deaths from cervical cancer were in the 65 and over age group. Concentrated effort must be applied towards the detection of cervical cancer in women over age 55. It should be noted, however, that 18.6% of the deaths from cervical cancer in Florida during 1970 occurred among

women aged 25-44 years, despite extensive cervical cytology screening being carried out in the state. This age group is quite valuable to the community and has the greatest responsibility for the care of many children.

## The ADC Project

A monograph, "Cervical Cancer Detection through Cytology," was published by the Division of Health as monograph number 11, 1967.<sup>1</sup> This is a report of a study of 10,174 Aid to Dependent Children (ADC) recipients during the period of 1960-1963 carried out with the assistance of the U. S. Public Health Service. This was one of the first times that a program of this magnitude had been attempted within 18 counties of a state.

The program goal was to screen a large proportion of an indigent, underprivileged and high-risk group of women. During the period, 10,174 women were screened. About 400 or 4% were referred to tumor clinics because of abnormal cytology—Pap III, IV and V. This underprivileged group was biopsied and 205 or about 50% were positive for in situ or invasive cervical cancer; most were treated by indicated methods.

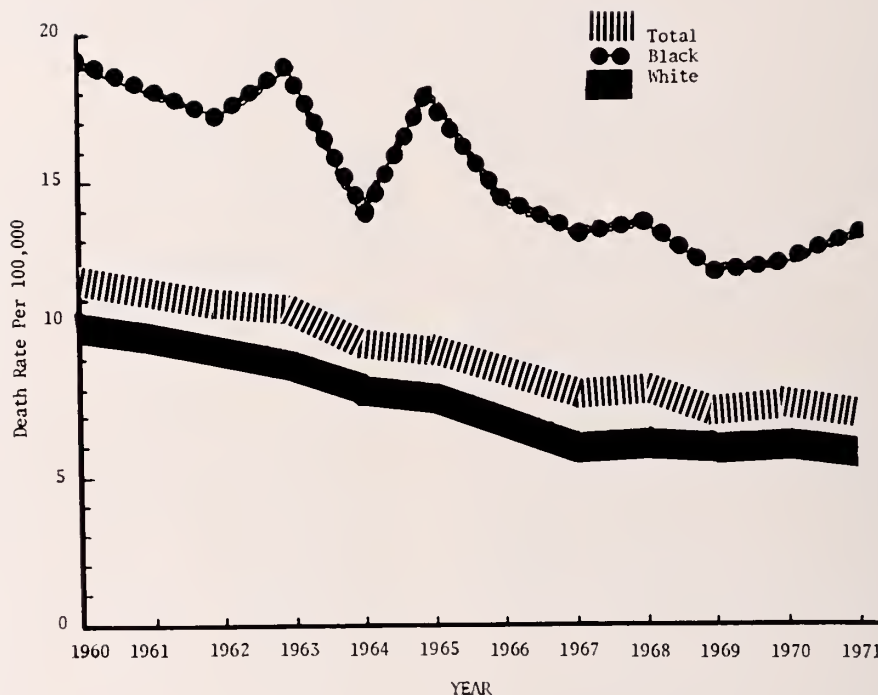
This project did much to raise the index of suspicion as to cervical cancer in Florida. Much valuable information was gained as to the natural history of cervical cancer and resulted in the refinement of techniques applicable to active mass screening.

The ADC Cancer Detection Program, whose influences extended into all sections of the state, has been a source of satisfaction for the official and voluntary health agencies who participated. Its beneficial aspects have continued through the years in many ways, but primarily in demonstrating to the county health departments that permanent ongoing cervical cytology programs for all indigent females could be established as an added service to their already ongoing disease control activities.

Since 1963, most directors of county health departments have established cervical cancer programs as a part of their county health department services. This has been accomplished with financial assistance from the Division of Health, American

Dr. Fulghum is Chief and Mr. Reagan is Health Program Specialist, Florida Division of Health, Jacksonville. Dr. Fulghum is also Director of Project #39, "Cervical Cytology for Certain Hospitals and Health Departments."

FIGURE 1  
CANCER OF CERVIX - DEATH RATE  
Per 100,000 Females by Race  
Florida 1960-1971



Cancer Society, Florida Division, Inc., U. S. Public Health Service, and in recent years—by a three-year grant from the Florida Regional Medical Program.

In 1967, the American Cancer Society, Florida Division, Inc., entered into the cytology program with the Division of Health, and it has been a valuable colleague in aiding with financial support in a number of Florida counties as well as providing excellent public education support to the program. The Florida Division of the American Cancer Society has provided its assistance to screen the underprivileged high-risk group of women through certain county health departments, as has the Division of Health. In 1971, some 63,000 medically indigent women were screened by county health departments or specially selected outpatient hospital clinics. In 1972, Pap examinations were performed on about 97,000 Florida women through the combined efforts of the Division of Health, county health departments, American Cancer Society, Florida Division, Inc., and Florida Regional Medical Program. This figure

does not include the many thousands of examinations performed by physicians on private patients. Approximately 200 cases of previously unknown cervical cancer were diagnosed and brought to treatment during 1972 by sponsored cancer programs.

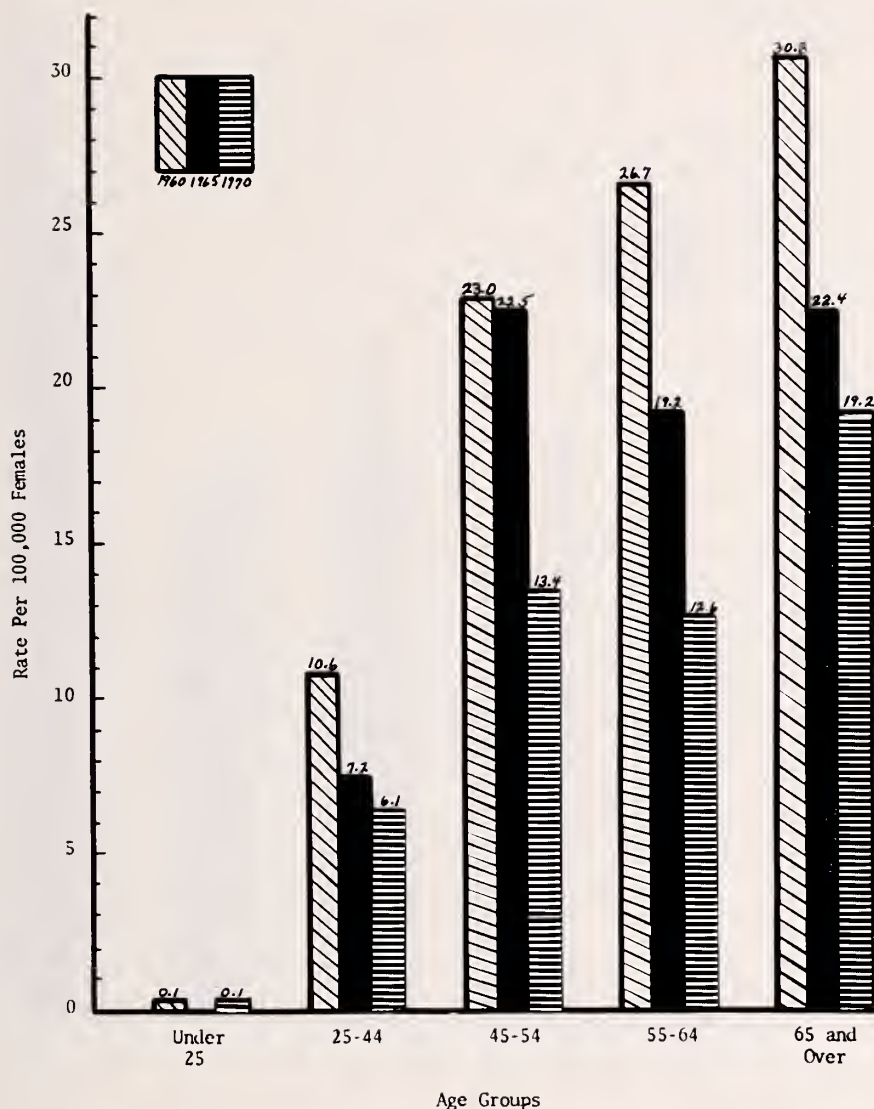
#### The FRMP Component

In 1967 and 1968, the U. S. Public Health Service, through its Cancer Control Program, funded several cytology projects directly to certain hospitals in the state. When the cancer program was sacrificed on the altar of economy by high-level decisions, this left the Public Health Service sponsored activity without support.

In 1969, the Division of Health, on the strong recommendation of the Florida Cancer Council and Cancer Task Force of the Florida Regional Medical Program, made application to FRMP and a three-year project grant was approved to operate cervical cytology programs in certain hospitals and health departments. This is known as Project #39.



FIGURE 2  
CERVICAL CANCER DEATH RATES PER 100,000  
Females by Age Group  
Florida 1960, 1965 and 1970



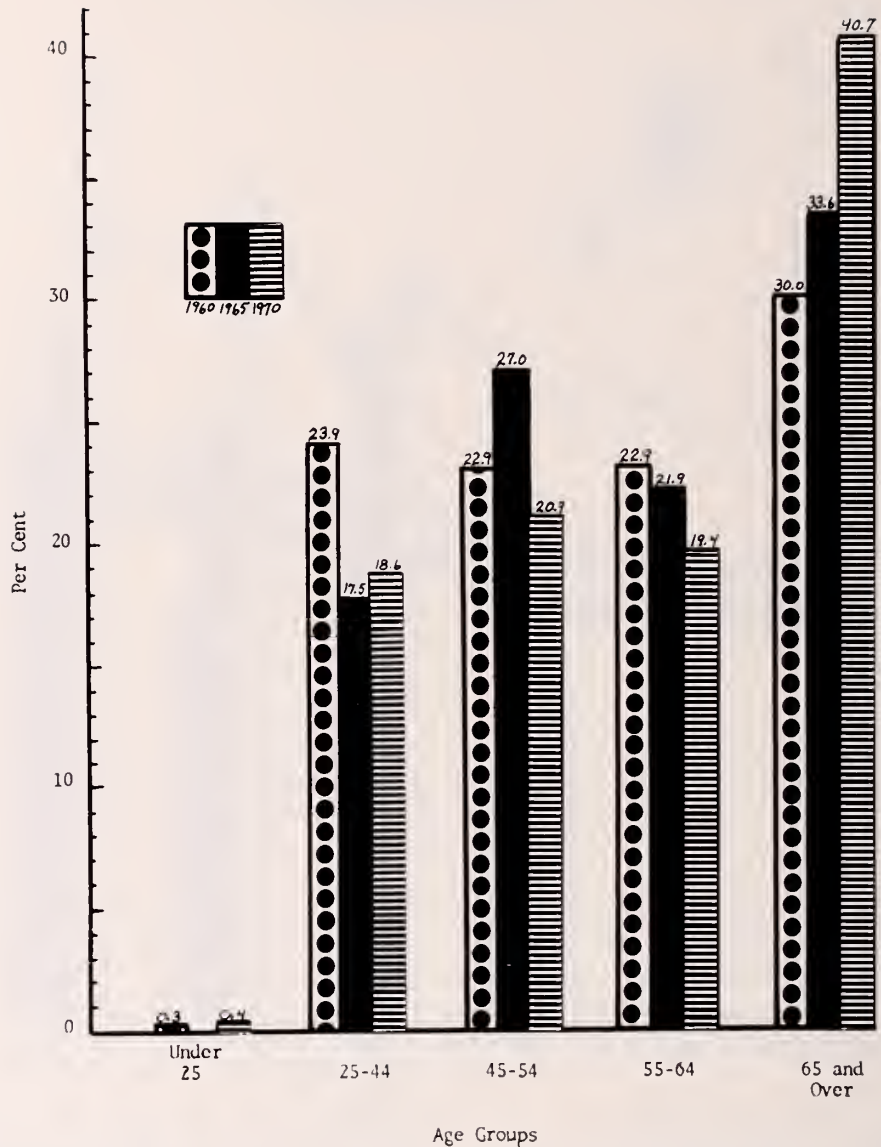
Three centers were established during the first year of the project's operation: Jacksonville, University Hospital of Jacksonville; Miami, Dade County Department of Public Health; and Tampa, Hillsborough County Health Department. During the second year of operation, the project added a fourth center, Pensacola located in the Escambia County Health Department. This expansion completed a statewide network of large scale cervical cytology screening centers. The Florida Regional Medical Program grant support is scheduled to terminate in April, 1974.

**ORGANIZATION**—Under the project director, each center has a codirector who is responsible for the program's operation. Each center has two

employees, a public health nurse (or clinic nurse) and a clerk or secretary. This seems to be the optimum number for staffing the centers. The average workload for the four centers is about 2,400 persons screened per month.

**THE COSTS**—Cost for screening to follow-up to treatment has been just under \$5 per person. Fifty-three cents of each dollar pays laboratory fees for slides processed. Each center has been free to negotiate with the local pathologist on a fee for service basis. Forty-two cents of each dollar pays the salaries of the eight full-time employees assigned to the four centers. The time to the project director, the four codirectors and other county health department personnel involved in the

FIGURE 3  
CERVICAL CANCER DEATHS PER CENT BY AGES  
Florida, 1960, 1965, 1970



follow-up and treatment of patients is not paid from nor charged to the project grant. Four cents of each dollar goes for expendable supplies used by the centers. These are purchased through state contracts and result in considerable savings to the project. One cent of each dollar goes for staff travel expenses.

#### Long Range Objective

The long-range objective of Project #39 is to reduce the mortality from cervical cancer among high-risk females, i.e., those from low socioeconomic backgrounds and/or minority groups. Minority groups include Indian, Spanish-American and Blacks.

Annual short range objectives of Project #39 are to screen approximately 12.6% (4,400) of the target population in Jacksonville; 11.5% (11,500) of the target population in Miami; 8.6% (3,000) of the target population in Tampa and 18.9% (3,000) of the target population in Pensacola.

#### Target Group

From its inception Project #39 has accepted for testing all females of sexual maturity presenting themselves to the screening clinics. All of these programs are readily accessible to the target population; i.e., medically indigent, high-risk, predominately minority group females. Studies indicate that 97% of the females served by the four

projects are classified as being in the target population.

The Tampa program utilizes another Florida Regional Medical Program Community Interaction Project which employs health guides for a model neighborhood area to make known to the women of the area the availability of the center's medical services. They are also of assistance in follow-up of the women who screened positive. Another center utilizes the local Voluntary Health Agency to provide follow-up services and transportation for many persons who require assistance to get to the center. In other instances, the assets and resources of the community were used effectively to further the program at no expense to the project.

### Findings

Since the beginning of screening in June, 1971 some 40,368 persons have been screened for cervical cancer by the use of Papanicolaou examination. The total yield of positive biopsies for this group is 54 cervical cancers, most of which are in situ lesions. All patients have been referred for treatment and most have been treated or are awaiting treatment. These findings are somewhat above the number of previously undetected cervical cancer that we expected to find when the program was planned.

When we compare the rate of 1.3 cancers per thousand females tested for Project #39 to the rate of 20.4 per thousand found during the ADC Project, one might be somewhat disappointed with the yield today. It should be remembered that the ADC group had never been screened previously. The findings today are a tribute to the work previously carried out in the state from 1963 to 1971. Samuel Gunn, M.D., of the Department of Pathology, University of Miami School of Medicine, often refers to the phrase now being used in scientific cytology circles, the "Vanishing Positive Smear."<sup>2</sup> This is a desirable goal that we wish to attain—no more deaths from cervical cancer. In addition to the suspicious and positive Pap smears, many persons were found with moderate to severe dysplasia, inflammatory changes, trichomonas and other sources of chronic infections. These individuals were urged to seek gynecological care in the hope of preventing in situ lesions of cervical cancers.

### Summary

In summary, the findings for Project #39 for the period, June 1, 1971, to December 31, 1972, are as follows:

Total persons screened	40,368
Total suspicious and positive Paps	102
Number referred	124
Positive biopsies for cancer	54
Number cancer cases treated	53
Number cancer cases pending treatment	1
Other chronic conditions such as moderate to severe dysplasia and trichomonas	327

The Florida Regional Medical Program, by providing financial assistance to the Division of Health, has been most helpful at a time when it appeared that some cytology programs would have to be discontinued. The Cervical Cytology Program has continued and expanded to include four active screening centers in populous areas of the state. It would appear at this time that the programs in the four individual centers, funded in part by FRMP, will be continued when the project is phased out.

### Uterine Task Force

The Uterine Task Force of the American Cancer Society, Florida Division, Inc., in keeping with the trends of the American Cancer Society, has as its goal "to insure that by 1976 a Pap test is obtained by every woman over 19 years of age in Florida, including those women under 19 who are at special risk." The goal is 2,400,000 women to be tested in the next four years. Careful consideration must be given to how the medically indigent females with suspicious and positive findings can be followed to diagnosis and treatment.

### Conclusion

In conclusion, it seems timely to point out that it costs about \$5 to screen a woman for cervical cancer. It costs \$17,500 to treat her for invasive carcinoma of the cervix and then she may very likely lose her life.

Which is the best public health approach? If one fourth of the money now spent by the state on medically indigent women with invasive carcinoma of the cervix and uterus could be used in an examination program utilizing the Papanicolaou method, society would gain considerable in tax dollars spent, not to mention the consideration of lives saved and happiness of the individuals at risk.

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# RMP! - RIP?

H. PHILLIP HAMPTON, M.D.

The Congress enacted Regional Medical Programs legislation in 1965 following consideration of the report of a Presidential Commission appointed to study national health problems. The Commission recommended federal financial support to establish regional systems for health care delivery centered around medical school affiliated hospitals to provide diagnosis and treatment especially for heart disease, cancer and stroke.

The Congress rejected this proposal but enacted legislation providing federal funds to: "(1) assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training, including continuing education, for medical data exchange, and for demonstrations of patient care in the fields of heart disease, cancer, stroke, and kidney disease, and other related diseases; (2) afford to the medical profession and medical institutions the opportunity of making available to their patients the latest advances in the prevention, diagnosis, treatment and rehabilitation of persons suffering from these diseases; (3) provide regional linkages among health care institutions and providers in order to improve primary care and the relationship between specialized and primary care; and (4) improve generally the quality and enhance the capacity of health manpower and facilities and to improve health services for persons residing in areas with limited health services and to accomplish this without interfering with the patterns, or the methods of financing, of patient care or professional practice or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from voluntary health agencies."\*

Initial development of Regional Medical Programs was largely dominated by the faculty of medical schools who often were not entirely disabused of the original Commission proposal. Practicing physicians generally were wary of

federally financed influence on cooperative arrangements of health care providers.

Many of the initial projects were campus oriented and hardly apparent to the community physician and patient. Others were outstanding successes, such as aid to development of coronary care units. Some of the projects of the Florida Regional Medical Program are described in this special supplement to the Journal of the Florida Medical Association.

Gradually RMP regional organizations became more autonomous and oriented to their particular health care problems. RMP's were at their best in the low key role of support to health care and evaluation.

The recent decision of the Administration to deny continued federal financial support to RMP's was founded apparently on insufficient evidence of concrete results to justify the money spent and "because the regional system of health care as originally envisioned has not in fact been realized in the seven years of the programs' existence." The RMP law as enacted by the Congress forbids the program to develop regional systems of health care delivery and the action of a catalyst cannot be readily measured.

Need for the development of cooperative arrangements between health care providers and educational institutions is as great as ever. Now that government is directly financing the cost of health care for 38% of the population, the need for liaison between government and the private medical sector is greater than ever.

The recently enacted PSRO law gives physicians and medical societies the initial opportunity to formally assume enormous responsibilities for the evaluation and monitoring of health care delivery. They need expertise and technical support to fulfill the expectations.

RMP was beginning to develop the provider support to aid in meeting those needs. If the RMP organization is destroyed, what will take its place?

Dr. Hampton is Chairman of the Board of Directors of Florida Regional Medical Programs, Inc.

\*From PL-89-239.

► Dr. Hampton, 1 Davis Boulevard, Suite 507, Tampa 33606.

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WDS



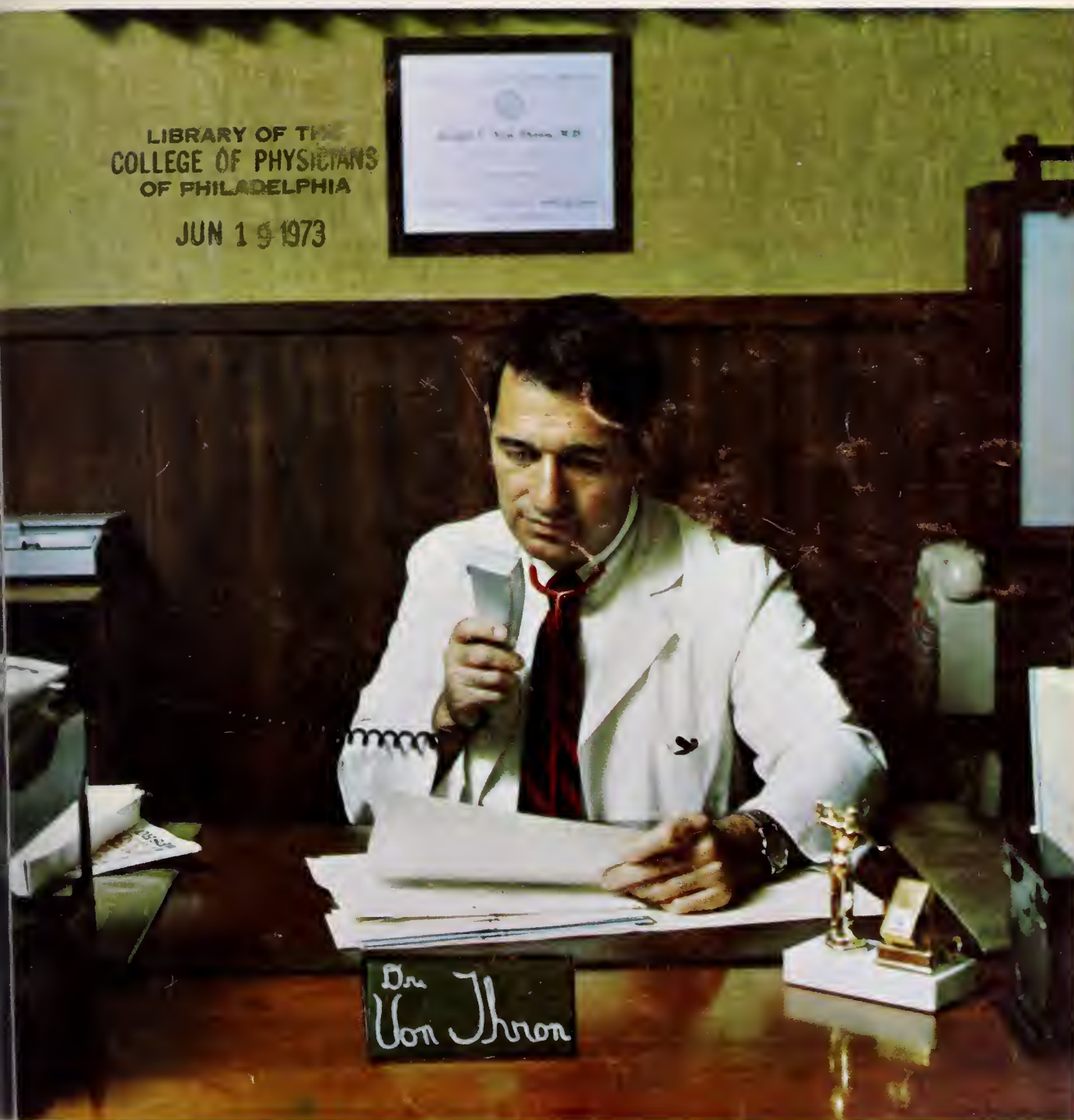
VOL. 60, NO. 6

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JUNE 1973

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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JUNE COVER—Joseph C. Von Thron, M.D., of Cocoa Beach, became the 97th President of the Florida Medical Association, May 13, 1973.

## President's Page



### I Will Do My Best

Many of you have been a part of the FMA for much longer than I; however, most of you have not had the opportunity to see the FMA from the position to which you have elevated me. The President is the one person in a position to see an organization as a whole. He has no departmental loyalties or council affiliations to influence his perception. He has the opportunity, if only he can grasp the vision, to view the entire enterprise and to sense its total import.

In the last 365 days, as your President-Elect, I have been on an exploration for discovery. Let me share with you what I think I have learned, and to think aloud with you about where we might be going.

The first thing I learned is that the FMA is big—bigger than I had imagined—big in so many ways. In membership we are bigger in population than Marianna, or Belle Glade, or even Vero Beach! Comparatively, we have more licensed physicians in Florida than all the other states except New York and California. Our Journal includes more pages of advertising than any other state journal. Our total assets, including buildings and equipment, are worth over one million dollars. Our state association ranks eighth among all the states in total enrollment. We transport over 25,000 pieces of mail every month, all of which seems aimed at inquisitive physicians. We employ 28 full time employees, under the direction of a most efficient Executive Vice President, Harold Parham. FLAMPAC, our political action association, was recently honored in Washington by AMPAC as the "best all around PAC" in the nation. Your president spends approximately 50 days during his tenure of office serving the FMA.

We are also big in ways which are not so admirable to recite. Bluntly, we are big in unmet needs. We are consistently high in developing medical services, but at times consistently low in the eyes of too many of our own members. With dismay I discovered that, in overall activity, we daily improve the calibre of health care delivery; but, often lag in overall concern for the providers—our members.

In short, we are big in members, big in scope, big in program activity, big in responsibility, big in opportunity to serve, and big in obligations to contribute. We may also be big in confusion.

At any rate, as President, I will do my best to make Florida Medical Association big in answering the needs of our members.

Thanks for letting me try.





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**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

**Precautions.** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

**How Supplied.** Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

**ROERIG **

A division of Pfizer Pharmaceuticals  
New York, New York 10017

# Clean Sweep



## with a single dose of Antiminth

(pyrantel pamoate) ORAL SUSPENSION

Highly effective against  
pinworm and roundworm

Non-staining to teeth  
or oral mucosa on ingestion, to  
tools, clothing, linen

Simple dosage with a  
single-dose regimen: 1 cc. per  
10-lb. body weight (1 tsp./50 lb.;  
maximum dose, 4 tsp.)

Well-tolerated, based on  
clinical studies\*

Pleasant-tasting, easy-to-  
take, caramel-flavored oral  
suspension

Economical, because one  
prescription can treat the entire  
family

**ROERIG** *Pfizer*

A division of Pfizer Pharmaceuticals  
New York, New York 10017

# ANTIMINTH<sup>®</sup>

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

While Antiminth is highly effective against pinworms and roundworms, the illustration is not meant to imply 100% efficacy.  
\*Data on file at Roerig. Please see prescribing information on facing page.

**What's  
on your  
patient's  
face...**

**may be more important than  
his chief complaint**



The lesions on his face may be solar/actinic — so-called "senile" keratoses...and they may be premalignant.

## Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



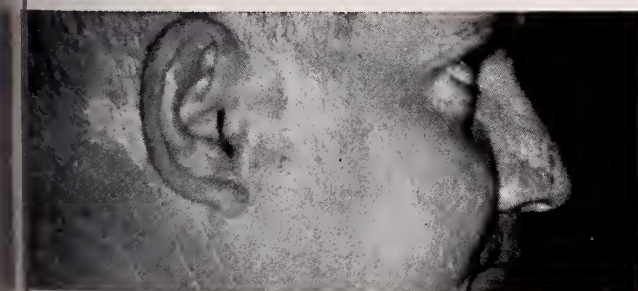
Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on edge of nose from previous cryosurgical and electro-surgical procedures.

## Sequence of therapy/ Selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; the reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

## Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5%-FU cream. Reaction has subsided. Residual scarring not seen except for that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

data on file, Hoffmann-La Roche Inc., Nutley, N.J.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local — pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported — insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with non-metal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers — containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes — containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

This patient's lesions  
were resolved with

**Efudex®**  
**(fluorouracil)**  
5% cream/solution  
...a Roche exclusive



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

### Of Primary Concern

CHANDLER A. STETSON, M.D.

Having survived our first six months in Gainesville without developing chest pain, bleeding ulcer or acute depression, we take pen in hand to make the first of what we hope will be at least several contributions to the "Dean's Page." This one will consist of a brief account of the current situation of the school, a few of its more pressing problems, and some of our hopes for its future. Subsequent reports will deal in more detail with specific programs and their development, and we earnestly invite comments and suggestions from interested readers.

This school, as we see it, is on the verge of a new phase in its existence. After an initial period of development in the late fifties and early sixties, it went through a phase of consolidation and program improvement and curriculum reform. It is now entering upon a major expansion program which is expected to result in a doubling of class size, and it faces new opportunities and new challenges to which it should be able to respond in creative and effective ways. The faculty is strong, the facilities are good, the student body superb, and the sense of mission and commitment to excellence is undiminished. Current construction programs, scheduled for completion in phases over the next eighteen months, will provide us with unmatched teaching facilities. Upgrading our hospital support facilities and expansion of patient care and clinical teaching facilities are also progressing, although more slowly than we would wish. All in all, we find a solid base here on which it should be possible to build effectively over these next few years.

Emphasis in our educational program continues to be on the improvement of our integrated basic science teaching, on finding new and more effective ways to expose students to modalities of primary care, and on flexibility in permitting students to choose those areas in which their individual con-

centration and independent study can best serve their own long-range career goals. In the area of continuing education, we hope to build on those programs which have been effective in the past and to develop new programs which will be of interest and value not only to our alumni but to all other interested Florida practitioners.

The sudden, unexpected and drastic cut-backs in federal support to medical students and medical schools constitutes one of our most serious problems. These cut-backs are now hurting our students and our school, and can be expected to hurt more in the future. To the extent that these cut-backs curtail or cripple the research and research training programs here, we will be attempting to maintain balance by seeking support from other sources. The extent in which they cripple our basic teaching and clinical programs, constitutes a serious threat to the major mission of this school, a threat to which we must respond with vigor and conviction. Planners in Washington have indicated they wish the nation's medical schools to raise tuition to reflect the entire true cost of medical education, that medical students should be prepared to pay in the neighborhood of \$10,000 or more per year just for their tuition charges in medical school. There is no civilized country today in which this is done, and the impact of this on students from families of modest means would surely be unconscionable. In another area, the complete termination of support for training programs which is scheduled to begin shortly would, if permitted, dry up production of specially trained medical manpower. While this move on the part of Washington is apparently designed to cope with past overproduction in such fields as biochemistry and the surgical subspecialties, it is being applied so indiscriminately as to threaten the supply of pediatricians, psychiatrists and a good many other clinical specialty areas in which there is most certainly not an oversupply now or in the near future. We will be working, with other schools, to

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Dr. Stetson is Dean, University of Florida College of Medicine, Gainesville.

persuade the Congress to make a fair, thorough and thoughtful re-evaluation of this problem.

Finally, at a time when it is a matter of national policy to encourage development of new medical schools and expansion of established schools, to educate more physicians particularly for general practice and for the so-called "primary care" areas of medical practice, it is frustrating and counter-productive to see total withdrawal of funds for construction, renovation or expansion

of medical school classrooms and other facilities, and massive cut-backs in funds for training and support of the needed new faculty members. These and similar problems, stemming from federal cut-backs, are of primary concern to medical educators today and we are in the process of attempting to assess their impact and long-range consequences for our College of Medicine.

► Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.



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# Rondomycin<sup>®</sup>

## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas, and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

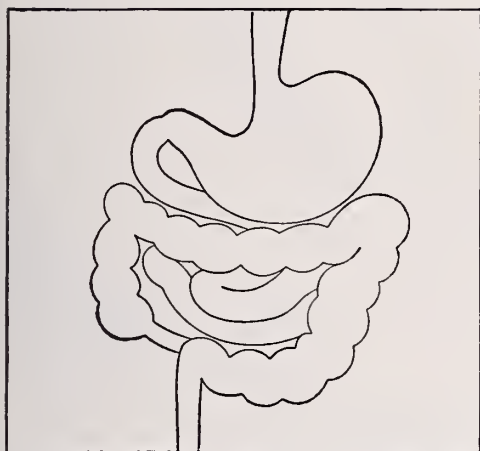
Before prescribing, consult package circular or latest PDR information.

Rev. 12/71



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# in “Gasspastic” conditions



The GI tract in spasm is commonly a “gas trap.”

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that “lyses” gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gastritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

**Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.**

Sidonna can do more for your “gasspastic” patient. Try him on 1 or 2 tablets before meals and at bedtime.

# Sidonna®

Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

## can do more

**Contraindications:** Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.

**Side Effects:** Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

**Reed & Carnrick/Kenilworth, New Jersey 07033**



# Now form follows function

Only **Candeptin** (candicidin) gives you this unique form... a soft gelatin capsule—highly effective therapy for all your vaginal moniliasis patients



**CANDEPTIN® (candicidin) VAGELETTES™ Vaginal Capsules**... a unique dosage form... anatomically and therapeutically designed to extend flexibility in the treatment of vaginal moniliasis.

## **Virtually unlimited application**

CANDEPTIN VAGELETTES Vaginal Capsules provide the specific high potency antimicrobial agent, candicidin, in a soft gelatin capsule—the shape designed with your patient in mind. It permits easy manual insertion without the need for an applicator or inserter... of particular value for the pregnant patient... for *intravaginal use*. By cutting off the tip of the narrow soft end, the contents can be extruded through an intact hymen for *intravaginal use*. And it is readily adaptable to *topical application* for labial involvement, and/or *intravaginal use* to treat mucosal infection.

**CANDEPTIN (candicidin) provides:**

## **Rapid results**

Prompt, symptomatic relief—itching, burning, and discharge subside in 48-72 hours.<sup>1</sup>

Soothing, miscible ointment permits complete contact with affected tissue.

Usually cures in a single 14-day course of therapy.<sup>2,3,4</sup>

## **Safe**

Exact dosage assured.<sup>2,3</sup>

No side effects, clinical reports of irritation or sensitization extremely rare.

## **Convenience**

Easy to use intravaginally and/or topically for labial involvement.

Encourages patient acceptance and cooperation. Therapy is easy to start in your office.

## **Clinical proof of potency**

CANDEPTIN (candicidin) is significantly more potent *in vitro* than nystatin.<sup>5</sup> CANDEPTIN Vaginal Ointment and Tablets have a clinical record of cure rates of 90% and more in pregnant and non-pregnant patients.<sup>1,4,6</sup> In recent studies on CANDEPTIN VAGELETTES Vaginal Capsules, involving both gravid and non-gravid patients, a 100% culture-confirmed cure rate was achieved with a single 14-day course of therapy.<sup>2,3</sup>

## **Unique**

**CANDEPTIN® (candicidin)  
VAGELETTES™ Vaginal Capsules**



**Description:** CANDEPTIN (candicidin) Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate. CANDEPTIN VAGELETES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.

**Action:** CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETES Vaginal Capsules possess anti-monilial activity.

**Indications:** Vaginitis due to *Candida albicans* and other *Candida* species.

**Contraindications:** Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

**Caution:** During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

**Adverse Reaction:** Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETES Vaginal Capsules have been extremely rare.

**Dosage:** One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

**Available Dosage Forms:** CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN VAGELETES Vaginal Capsules are packaged in boxes of 14 (14-day regimen requires 2 boxes.)

Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

**References:** 1. Olsen, J.R.: *Journal-Lancet* 85: 287 (July) 1965. 2. Giorlando, S.W.: *Ob/Gyn Dig.* 13: 32 (Sept.) 1971. 3. Decker, A.: *Case Reports on File, Medical Department*, Julius Schmid. 4. Giorlando, S.W., Torres, J.F., and Muscillo, G.: *Am. J. Obst. & Gynec.* 90: 370 (Oct. 1) 1964. 5. Lechevalier, H.: *Antibiotics Annual 1959-1960*. New York, Antibiotica Inc., 1960. pp. 614-618. 6. Friedel, H.J.: *Maryland M.J.*, 15: 36 (Feb.) 1966.



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## MEETINGS

National and Regional  
Meetings Held in Florida

### JULY

- 4- 7 Cuban Medical Association in Exile, Americana Hotel, Miami Beach. Pres.: Enrique Huertas, M.D., P.O. Box 1016, Coral Gables 33134.

### SEPTEMBER

- 27-29 National Conference on Cancer of the Colon and Rectum, sponsored by American Cancer Society, Americana Hotel, Miami Beach. Info.: Sidney L. Arje, M.D. American Cancer Society, 219 East 42nd Street, New York 10017.

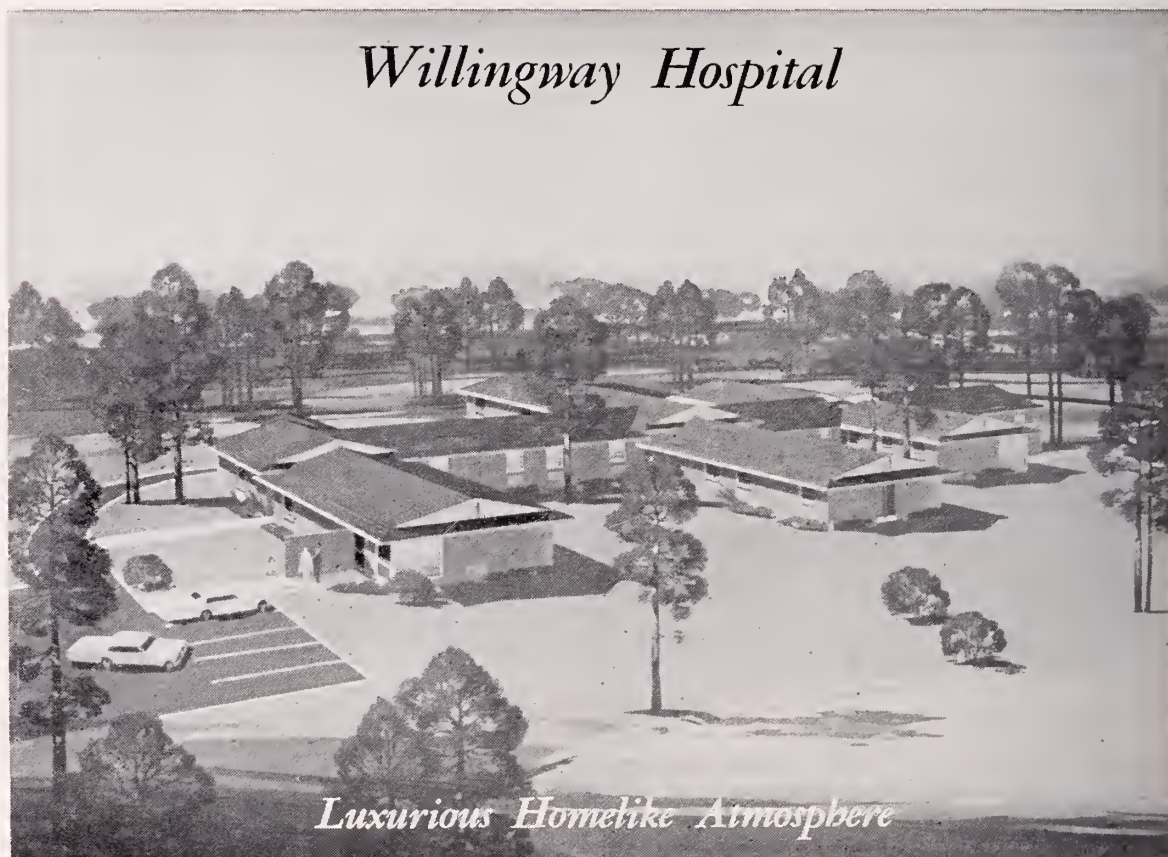
### OCTOBER

- 1- 5 American Association for Laboratory Animal Science, Americana Hotel, Miami Beach. Exec. Sec.: Mr. Joseph Garvey, 2317 West Jefferson Street, Joliet, Illinois 60435.
- 11-13 American Society for Colposcopy and Colpomicroscopy, Sonesta Beach Hotel, Key Biscayne. Pro. Dir.: Adolfo C. Corzo, Symposia International, P. O. Box 580, Tujunga, Calif. 91042.
- 20-21 American Association for Hand Surgery, Diplomat Hotel, Hollywood. Sec.: Kim K. Lie, M.D., 27500 Hoover Road, Warren, Michigan 48093.
- 21-26 American Society of Maxillofacial Surgeons, Diplomat Resorts, Hollywood. Sec.-Treas.: Samuel Shatkin, M.D., 50 High Street, Buffalo, N.Y. 14203.
- 21-26 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Hollywood. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

### NOVEMBER

- 5- 9 Gerontological Society, Miami Beach. Exec. Dir.: Mr. Edwin Kaskowitz, One DuPont Circle, Washington, D. C. 20036.
- 7-10 American Medical Women's Association, Palm Beach. Exec. Dir.: Mrs. Gertrude Conroy, 1740 Broadway, New York 10019.
- 11-16 American Association of Blood Banks, Miami Beach. Office Mgr.: Miss Lois J. James, 1828 "L" Street, N.W., Washington, D. C. 20036.

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not if the vasodilator is

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The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

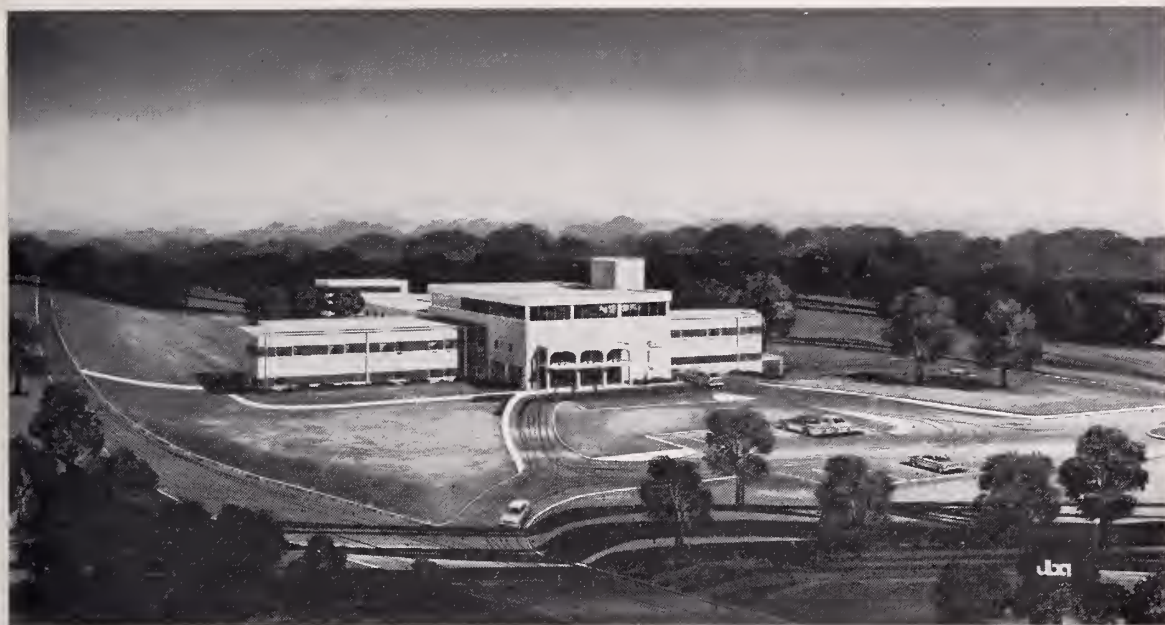
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**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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## Extracranial-Intracranial Vascular Microanastomosis

### Preliminary Report

GASTON J. ACOSTA-RUA, M.D.

It is not unfrequent to encounter a patient with a totally occluded internal carotid artery where the contralateral carotid artery should supply the entire anterior circulation. These patients often develop episodes of transient ischemic attacks.

Experimental by-pass between extracranial-intracranial vessels has been well documented. Donaghy and Yasargil<sup>1</sup> described the techniques of anastomosis between the superficial temporal artery and a branch of the middle cerebral artery in the dog. Reichman<sup>2</sup> reported his experimental lingual-basilar arterial anastomosis. Acosta-Rua and Yasargil<sup>3</sup> reported a by-pass between the superficial temporal and the posterior communicating arteries in the dog.

Clinical application of these techniques are also well described in the literature.<sup>1,2,4</sup>

This is a report of three patients with complete occlusion of the internal carotid artery with an inadequate collateral circulation.

A termino-lateral anastomosis was performed between the superficial temporal artery and the temporal division of the middle cerebral artery. A small cortical artery instead of the middle cerebral trunk was used for anastomosis in order to decrease the risk of the surgical procedure.



Fig. 1.—Pre-operative angiogram shows complete occlusion of the left internal carotid artery in the neck. (lower arrow) There is filling of the external carotid artery and all of its branches including the superficial temporal artery (upper arrow). Notice that there is no filling of the intracranial circulation.



Fig. 2.—Post-operative angiogram shows an anastomosis between the superficial temporal artery and a cortical branch of the middle cerebral artery. (arrow)

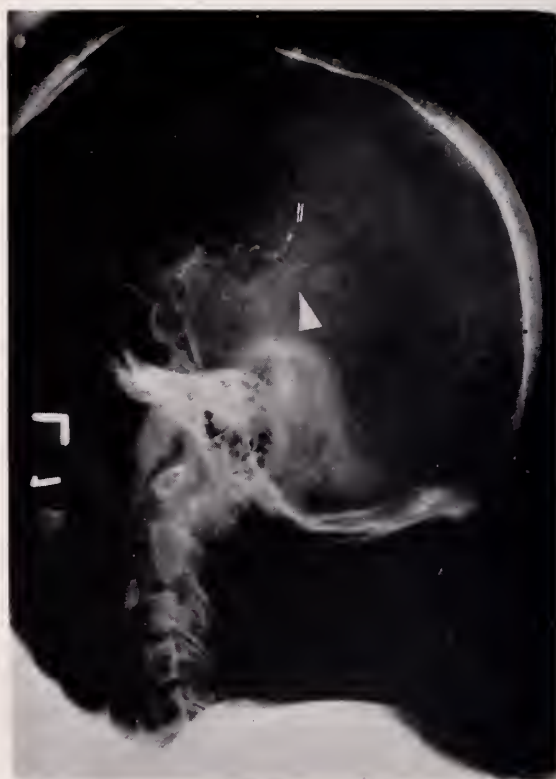


Fig. 3.—Late arterial view of the same angiogram shows filling of the middle cerebral group via the extra-cranial-intracranial anastomosis.

Of the three patients, two have improved and the other remains unchanged. Details of the clinical improvement as well as follow-up angiography will be reported.

The basis of the procedure is to increase vascular blood supply and collateral circulation but the specific indications have not yet been well delineated and for this reason, these patients must be evaluated as individuals.

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► Dr. Acosta-Rua, 2545 Riverside Avenue, Jacksonville 32204.

No immediate relief from Phase 3 controls on physicians' fees was offered by John D. Twiname, Executive Director of Health of the Cost of Living Council, as he addressed the AMA congress. He conceded that Phase 3 penalizes physicians and thanked the AMA and the nation's physicians for cooperating with Phases 1 and 2. He said physicians could keep pace with wage earners who are allowed 5.5% salary increases by boosting their productivity 3% annually and raising fees the maximum 2.5%. Meetings to devise a national health strategy are under way between HEW officials and members of the President's "Super Cabinet," he said, and a proposal can be expected within the next few months.

# A Rational Approach to Surgery of the Paranasal Sinuses

J. ANDREW BURNAM, M.D.

**Abstract:** The author focuses interest on the rhinogenic origin of most sinus problems, relating this origin to an anatomical and physiological means. The surgical indications are discussed and case histories presented to illustrate various surgical problems. Finally, the basic goals of sinus surgery are summarized.

The sinuses are, in fact, accessory structures of the nose with minimal functional value and exist as passive entities. Although the pathogenesis of sinus disease is occasionally obscure, most often it can be traced to two factors, ventilation and drainage. Ventilation occurs in the presence of open sinus ostia and open nasal passages. Proper drainage occurs in the presence of open sinus ostia, normal ciliary activity and good nasal respiration. The latter factor is important in producing a negative intranasal pressure to help promote sinus drainage. As passive structures, therefore, it is apparent that the paranasal sinuses are wholly dependent upon good nasal physiology for their continuing state of good health (Fig. 1).

Anatomically, the anterior and middle ethmoids, the frontals and the maxillary sinuses, can be considered one unit as they all drain into the ethmoidal infundibulum or its immediate proximity. This small funnel-shaped area in the middle meatus is thus the key to most rhinogenic sinus infections. Drainage and ventilation must be established here or an alternative route considered (Fig 2).

If the key to sinus disease lies in the nose, and particularly the ethmoidal infundibulum, what are the predisposing factors and what is their surgical treatment? Certainly, the most common cause of recurring sinus infection must be the deviated nasal septum (Fig. 3). Secondly, allergic problems, particularly polyps, are fre-

quently involved (Fig. 4). Other factors are dental disease, air pollution, trauma, and tumors. Any hope of alleviation of most rhinogenic sinusitis must, therefore, include nasal correction and appropriate measures for the allergic condition at hand.

Since most problems of sinusitis are of rhinogenic origin, it follows that corrective sinus surgery must be aimed at the nasal condition. Thus, the majority of sinus conditions can be handled via the nasal route. Usually, it is only the complications of sinus disease which must be

## Sinus Function Dependent Upon

1. Nasal and sinus ventilation
2. Adequate drainage
3. Active nasal respiration

Figure 1



Fig. 2.—Note the middle meatus receives drainage from ethmoidal, maxillary and frontal sinuses.

Dr. Burnam is a clinical assistant professor at the University of Miami School of Medicine, Miami.

Presented before the Section on Otolaryngology, 98th Annual Meeting, Florida Medical Association, May 5, 1972, Hollywood.



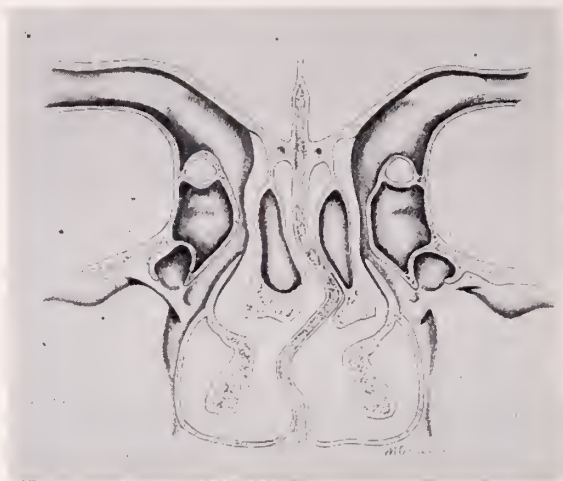


Fig. 3.—Pressure caused by a deviated septum is a common cause of headache. It also accounts for poor nasal ventilation and secondary sinus problems.

dealt with surgically through an external approach. This includes the classical Caldwell-Luc operation which actually has minimal application to most rhinogenic problems.

The following cases illustrate rhinogenic sinus disease of increasing severity:

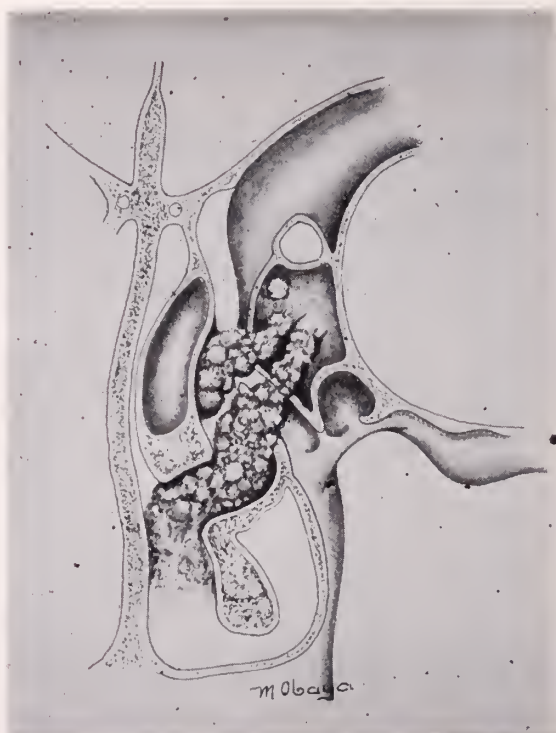


Fig. 4.—Nasal polyps commonly arise in the ethmoid sinuses and present in the nose. Adequate surgical therapy must include ethmoid exenteration.



Fig. 5.—Note the total opacification of the right nostril and the right paranasal sinuses. This is typical of allergic polyps.

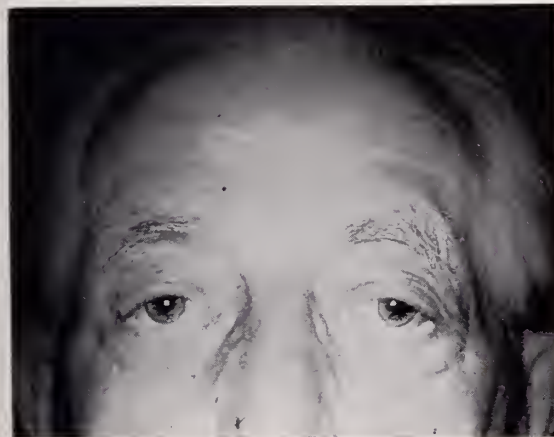
## Report of Cases

Case 1.—This 32-year-old male suffered with recurrent left sided headaches for several years. There were associated chronic nasal congestion, postnasal drainage and a history of previous nasal trauma. Examination revealed a severely deviated septum to the left and mucoid congestion. X-rays revealed clouding of the left antrum and ethmoid sinuses. Correction of the nasal septum, and left antrostomy and ethmoidectomy produced complete resolution of this problem.

Case 2.—This 18 year-old male had a one year history of chronic nasal congestion, postnasal discharge and right sided headaches. Examination revealed the right nasal cavity to be completely filled with nasal polyps. X-rays revealed a right pansinusitis. Septoplasty, right intranasal polypectomy, ethmoidectomy, antrostomy and sphenoidostomy were performed with very satisfactory results (Fig. 5).

Case 3.—This 37-year-old male was seen because of a three-week history of left-sided headaches and periorbital hypesthesia. There were no nasal symptoms of note. Examination revealed a high, posterior deviation of the nasal septum with congestive changes around the face of the sphenoid. Touch sensation, especially the left cornea, was diminished on the left side of the face. X-rays revealed a left sphenoiditis. Septoplasty and left sphenoidostomy completely corrected this condition.

Case 4.—This 83-year-old male had a prolonged history of hay fever and left nasal polyposis. The polyps had been removed nasally on one occasion. One year prior to the present examination he had onset of total blindness of the left eye. Now, he had a five-day history of left periorbital pain and swelling. Examination revealed marked left conjunctivitis and partial ophthalmoplegia. The left nostril was partially filled with polyps as well as mucopurulent material. X-rays revealed a left



Figs. 6-8.—The periorbital cellulitis is evident by the extreme proptosis and cellulitis. A laminogram reveals the cause, left ethmoiditis. A postoperative photograph reveals complete healing with no residual cosmetic problem.



Fig. 9.—A periorbital abscess has caused proptosis, blindness and total ophthalmoplegia.

pansinusitis with the exception of the frontal. Therapy involved a left external orbital exploration, ethmoidectomy, sphenoidostomy, and intranasal polypectomy. Recovery was complete except for vision (Figs. 6-8).

Case 5.—This 73-year-old female diabetic was admitted to the neurology service with left proptosis, blindness, and ophthalmoplegia. Nasal examination revealed congestion but no polyps or discharge. X-rays revealed a left ethmoiditis and antritis. A left orbital exploration and ethmoidectomy and sphenoidostomy was performed. An orbital abscess was found and drained. The patient did well for a few days but meningitis subsequently developed and she expired about three weeks postsurgery (Fig. 9).

### Discussion

Mosher has called the intranasal ethmoidectomy "the blindest and most dangerous of all surgery."<sup>1</sup> This operation, however, does not need to be performed blindly. In most cases, it is done with direct visualization. The common problems of visualization are caused by (1) deviated nasal septum, (2) nasal polyps, and (3) extremely narrow nasal passage. The first two should be overcome before the ethmoids are entered, followed by infracturing of the middle turbinate with direct visualization of the ethmoidal bulla. The anterior one third of the middle turbinate may be excised if it is very turgescient or engorged. Five percent cocaine with epinephrine is routinely used prior to onset of surgery to improve hemostasis, anesthesia, and visualization. In cases of an extremely narrow nose, this operation should not be performed by the occasional sinus surgeon.

### Summary

Nasal physiology and particularly the infundibular area of the nose are most important



in the pathogenesis of sinus disease. This area is the "Times Square" of the nasosinus labyrinth, and appropriate attention to its function will allow correction of the majority of sinus problems. Purposefully, little attention has been given to the frontal of maxillary sinuses. The predisposing factors in these sinuses are the same; however, treatment is usually merely a matter of establishing drainage and ventilation without intrasinus manipulation being necessary. This is achieved in the frontal sinus by anterior ethmoidectomy and in the antrum by inferior meatal antrostomy. If the antrum is solitarily involved, then dental or perhaps neoplastic origin must be considered. In these situations, the radical antrostomy approach may be necessary.

The basic goals of sinus surgery may be summarized as:

1. Alleviation of nasal and/or sinus obstruction.
2. Adequate nasal and sinus ventilation.
3. Eradication of chronic disease by sinus exenteration.
4. Surgical drainage of sinus complications.
5. Functional surgery without cosmetic deformity.

Finally, it should be remembered that the paranasal sinuses are passive appendages of the nose and will ordinarily remain disease-free when good nasal function is maintained.

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- Dr. Burnam, 8340 Northeast 2nd Avenue, Miami 33138.

## The Medical Records Mess

It is time for something to be done about medical records. We will admit that they are slowly improving in the hospital setting, prodded along by the Joint Commission requirements for history and physical, operative report and discharge summary. But, as we make utilization review rounds, we still run across illegible (or absent) progress notes, and we often find it hard to figure out what is going on with patients.

And the situation in the office is much worse. Dog-eared cards. Huge folders stuffed with multi-purpose slips of paper. Illegible handwriting. Hieroglyphic abbreviations without a Rosetta Stone. Old hospital summaries mixed with current progress notes. Nine EKG mounts to the inch. The medical auditor is first irritated, then frustrated and, eventually, despairing.

We think problem-oriented records\*, in which each patient's medical problems are listed by the number on a front sheet and each progress note refers to the present status of each problem,

constitute the beginnings of a way out of this morass. We suspect that our technology-oriented culture could help by devising color-coding, flow sheets and other system-planned methods. We hope that the computer will play an increasing role in solving the problem of obtaining patient data and storing and retrieving them. It can remind the physician to do things, it can help in the easy transfer of data from one physician to another and it can allow simplified medical audit and review.

It may be too late to teach oldsters these new tricks of record-keeping. But if fledgling doctors could be started out with them in their early training, it will only take a generation to have universal good records. Let's start soon.

\*Weed, Lawrence, *Medical Records, Medical Education & Patient Care*, Chicago, Yearbook Medical Publishers, 1970.

Reprinted from the Westchester Medical Bulletin, April 1971.



# Levodopa in Parkinson Patients With Cardiovascular Disease

MICHAEL S. GORDON, M.D., Ph.D., AND SHERIF SHAFAY, M.D.

**Abstract:** Twenty patients with cardiac disease and Parkinsonism were given levodopa and followed for up to 16 months. Continuous ambulatory electrocardiographic tape recordings were performed periodically. Five of the six patients who had cardiovascular problems while on levodopa had symptomatic and active cardiac disease prior to treatment. In three patients, angina increased. In two of these, it was related to an increase in activity. Quantitatively signifi-

cant ventricular premature contractions developed in two patients. One patient had a myocardial infarction, and the drug was discontinued.

It is suggested that the small risk of cardiac complications is acceptable in the treatment of patients with Parkinson's disease and that ambulatory electrocardiographic monitoring is useful in this setting for early recognition and quantitation of significant arrhythmias.

Cardiovascular side effects have been reported in numerous studies involving levodopa for the treatment of Parkinson's disease.<sup>1-5</sup> The most important include arrhythmias, particularly ventricular, and alterations in blood pressure, particularly postural hypotension.

Levodopa is a precursor of three catecholamines: dopamine, norepinephrine, and epinephrine. It is suggested that the beneficial effect of levodopa in patients with Parkinson's disease is due to an increase of dopamine in depleted areas of the substantia nigra.<sup>6</sup> On the other hand, an increase in dopamine, norepinephrine, and epinephrine may potentiate arrhythmias through their beta adrenergic stimulating effect. Postural hypotension may be due to attenuation of sympathetic nerve function by levodopa and possibly some degree of renal salt loss induced by both levodopa and dopamine.<sup>7</sup>

In a study of more than 1,500 patients, Langrall and Joseph found the overall incidence of cardiovascular side effects to be as high as 30.2%.<sup>8</sup> In this same series, however, only 15 out of 1,533 patients studied had to discontinue levodopa because of the severity of cardiovascular side effects, seven because of cardiac arrhythmias, eight because of postural hypotension.

We decided to do a joint cardiology and neurologic study of a group of parkinsonian patients with cardiovascular disease in an attempt to assess the risk involved in treating such patients with levodopa. These patients have now been followed for more than a year. We are reporting our preliminary findings.

## Patients and Methods

All patients with cardiovascular disease referred to one of us (S.S.) over a six-month period for evaluation and therapy of Parkinson's disease were admitted to the study and were hospitalized to initiate therapy. One patient, admitted to the study on the basis of an erroneous past history, was later found to have no evidence of heart disease (patient #1). Ultimately 20 patients with cardiovascular disease were studied.

Prior to beginning treatment with levodopa, all patients were seen by a neurologist and cardiologist and were re-evaluated at periodic intervals. Ten symptoms of Parkinson's disease were evaluated by the neurologist at each visit and rated on a 0-4 scale. These values were then totalled to give a numerical score at each visit. Change in the patient's Parkinson's disease was expressed as the percentage change of the score compared to the initial score (e.g., a patient whose score decreased from 50 to 25 had a 50% improvement).

From the Division of Cardiology, Department of Internal Medicine, University of Miami School of Medicine, and the Cardiology and Neurology Divisions, Department of Internal Medicine, Mercy Hospital, Miami.

Evaluation of the patient's cardiac status was performed by a cardiologist at each visit. Complete cardiologic history was obtained at the initial visit. Physical examinations, electrocardiograms, chest x-rays, and a 12-hour continuous electrocardiographic recording (using an Avionics Model 250 electrocardiocorder) were performed at regular intervals throughout the study. The Avionics electrocardiocorder provides a permanent electrocardiographic tape recording and as such is a most sensitive method of evaluating arrhythmias. It has been used extensively by various investigators. Iyengar, Castellanos and Spence<sup>9</sup> at the University of Miami have recently reviewed this technique in detail and concluded that it is invaluable in the diagnosis of transient arrhythmias and conduction disturbances in ambulatory patients.

The following parameters were graded on a 1-4 scale at each examination: overall functional classification (New York Heart Association and American Heart Association), angina, dyspnea, abnormalities on bedside examination, and the electrocardiogram with special reference to arrhythmias, particularly ventricular.

Most patients were receiving anticholinergic medications prior to starting levodopa; these were not discontinued. Six patients were receiving concomitant cardiac medications at the start of the study. These were altered at the discretion of the attending cardiologist on the basis of the patient's clinical status. The dosage of levodopa was titrated carefully for each patient according to clinical response, cardiac status, and presence or absence of side effects.

### Results

The results of the study are summarized in Table 1. In 14 of 20 patients, levodopa had no effect on the cardiac status. In five patients there were cardiac changes which, while they may have been related to levodopa therapy, did not necessitate discontinuation of the drug. The drug was discontinued in one patient (#6) who had a myocardial infarction while on levodopa. When levodopa therapy was reinstituted, she was unable to tolerate it.

### Case Reports

Patient #2: This 85-year-old man had occasional premature atrial contractions (APC's) on admission to the study. While on levodopa, these were seen occasionally on the continuous electrocardiographic record. On one occasion, at a dosage of 1.25 gm./day, he briefly had

a few ventricular premature contractions (VPC's). The number (three per hour for two hours) was judged quantitatively insignificant and, hence, were not treated (see Discussion). The patient is included for completeness only; as the degree of ventricular arrhythmias was insignificant, they were not treated, and they did not recur at higher doses of levodopa. He tolerated 6.0 gm./day of levodopa without evidence of adverse effect on his heart.

Patient #3: This 76-year-old woman with atherosclerotic heart disease and congestive failure showed frequent multifocal VPC's on her standard electrocardiogram, as well as on her continuous electrocardiographic record. She was receiving digoxin and thiazide diuretic. Regulation of her digoxin dose, and correction of hypokalemia and congestive failure resulted in a marked diminution of her VPC's. These increased again soon after levodopa was started. With the addition of quinidine her VPC's gradually diminished to a level considered quantitatively insignificant. Levodopa dosage was gradually increased to 3.0 gm./day. Her Parkinson state improved markedly and her daily activity increased. As a result she had some anginal pain which was controlled readily by vasodilators.

Patient #4: This 69-year-old woman had angina and left ventricular failure manifested by paroxysmal nocturnal dyspnea prior to entering the study. She became nearly pain-free and compensated on appropriate therapy. Six months after levodopa was begun, her angina increased (while on 2.0 gm./day) and she was ultimately controlled with enhancement of her cardiac regimen and slight reduction of levodopa to 1.75 gm./day.

Patient #6: This 66-year-old woman entered the study with a diagnosis of atherosclerotic heart disease with moderate anginal syndrome. Her symptoms were well controlled with medication. Approximately six weeks after starting levodopa, the patient had a myocardial infarction and the drug was discontinued. It was restarted one month later and the dose slowly increased to 2.5 gm./day. The patient continued to have chest pain. On 11/22/71, she was rehospitalized and her continuous electrocardiogram showed many VPC's. Levodopa was discontinued.

Patient #14: This 73-year-old man had a history of a myocardial infarction ten to 15 years before entering the study. His pre-drug electrocardiogram showed occasional VPC's and his cardiac status was stable. After two weeks on levodopa, his standard ECG, as well as his continuous recording ECG showed frequent VPC's (5/minute). Quinidine was started, following which his rhythm became normal. Levodopa was continued without further difficulty.

Patient #15: This 58-year-old man had a myocardial infarction three years before starting levodopa. He had a moderate but stable anginal pattern. He also had a history of congestive failure which was well controlled on digoxin at the time he entered the study. As his Parkinson's disease improved and he became more active, angina increased. This was controlled readily with a long-acting vasodilator and levodopa was continued.

Patient #21: This 71-year-old man had moderate hypertension and hypertensive cardiovascular disease for which he was receiving alphamethyldopa. Early in his treatment with levodopa, he developed a few VPC's which gradually increased in frequency. Quinidine therapy was instituted and the arrhythmia rapidly disappeared.

### Discussion

The cardiovascular effects of levodopa have been reviewed recently.<sup>7</sup> In essence, there are two significant side effects, postural hypotension and arrhythmias. Postural hypotension is rela-

Pt. #	Age	Sex	Concomitant Cardiac Medication	Dose of Levodopa Max/Last Gm.	Time on Levodopa at End of Study (weeks)	Overall Effect on Parkinsonism (% improvement)	Max. B.P. Drop mm. Hg.		Functional Class	Pretreatment Cardiac Status	Effect of Levodopa on Cardiac Status
							Systolic	Diastolic			
1	55	F	none	1.75/1.50	7-1/2	50%	10	0	0	no heart disease	none
2	85	M	none	6.00/6.00	60	60%	25	12	1	ASHD with abnormal ECG including frequent APC	developed rare (quantitatively insignificant) VBC's; L-dopa cont. & VPC's disappeared
3	76	F	Digoxin Thiazides Quinidine	3.00/2.50	20	60%	30	20	2	ASHD with CHF & frequent VPCs	developed angina, probably due to increased activity; L-dopa not D/C, and VBC's improved on appropriate Rx; difficult therapeutic problem*
4	69	F	Isordil	2.25/1.75	71-1/2	60%	40	10	3	ASHD & HHD with angina and CHF	all cardiac symptoms initially improved on Rx; after patient had been on treatment for 6 months her angina recurred & was improved with further cardiac Rx; L-dopa dose also reduced*
5	76	M	none	3.00/3.00	48	80%	12	2	1	ASHD with abnormal ECG, mild MR,S <sub>1</sub>	none
6	66	F	Hyd'od'uril Iso'dril Apresoline Lasix Digoxin	2.50/2.50	36-1/2	65%	40	20	2	ASHD-moderate angina	MI while on L-dopa; was D/C & restarted; on 2.5 gm. anginal pain, VPC's, dyspnea, Dopa D/C+
7	65	F	Thiazide Apresoline	2.25/1.75	59-1/2	80%	48	18	1	HHD with LVH	none
8	71	M	Digoxin	2.25/2.25	4	10%	20	12	1	ASHD with MR,S <sub>1</sub> & atrial arrhy.	none; dropped out of study after 1 mo. for personal reasons
9	68	F	none	3.75/3.75	47	45%	20	10	1	ASHD with MR,S <sub>1</sub>	none
10	59	M	none	2.25/2.25	8	20%	30	40	1	ASHD with S <sub>1</sub> intermittent MR	none; L-dopa D/C due to bleeding peptic ulcer and pneumonia
11	76	M	none	3.75/3.75	31	65%	20	10	1	ASHD with S <sub>1</sub> ,MR	none
12	67	M	none	3.75/2.50	28-1/2	65%	30	30	1	HHD with S <sub>1</sub> ,MR	none
13	66	F	none	2.25/2.25	4	N.A.	25	15	1	HHD with S <sub>1</sub> ,LVH	none; dropped out of study after 1 mo. for personal reasons
14	73	M	Digoxin Quinidine	3.75/2.25	34	40%	20	10	2	ASHD with history MI 10-15 yr ago VPCs	frequent VPC's controlled with Quinidine; L-dopa continued*
15	58	M	Digoxin Dyazide nitroglycerin	5.00/5.00	61	45%	20	10	2	ASHD with history MI 3 yr ago, angina	angina increased; controlled with vasodilators; L-dopa continued*
16	83	F	none	3.75/3.75	51-1/2	negligible	30	20	1	ASHD with abnormal ECG, LVH & angina	none; improved on cardiac treatment
17	63	M	none	3.50/3.50	21	45%	20	10	1	ASHD with abnormal ECG, S <sub>1</sub> ,MR	none



none	18	66	F	2.25/2.25	4	45%	20	10	1	HHD with S <sub>4</sub> , MR	none; dropped out of study after 1 mo. for personal reasons
19	70	F	none	3.25/3.25	20	45%	30	10	1	ASHD with abnormal ECG, S <sub>4</sub> , rare VPCs	none; VPC's rare; unchanged
20	55	M	none	3.25/3.00	13-1/2	20%	20	10	1	ASHD with rare angina	none
21	71	M	Quinidine Aldomet	3.75/3.75	61	60%	52	30	1	HHD with abnormal ECG, S <sub>4</sub>	increased VPC's on L-dopa; treatment with Quinidine and VPC's decreased*

Abbreviations: APCs -Atrial premature contractions  
ASHD -Atherosclerotic heart disease  
CHF -Congestive heart failure  
D/C -Discontinued  
HHD -Hypertensive heart disease  
LVH -Left ventricular hypertrophy

M1 -Myocardial infarction  
MR -Mitral regurgitation //  
S<sub>3</sub> -Pathologic third heart sound ventricular diastolic gallop  
S<sub>4</sub> -Pathologic fourth heart sound (atrial diastolic gallop)  
VPCs -Ventricular premature contractions

\* Possible cardiogenic effect of levodopa. Not necessary to D/C levodopa.  
+ Levodopa probable cause of cardiac symptomatology. ‡ Levodopa D/C.

// Abbreviations: In all cases above this refers to a hemodynamically insignificant degree of leak due to papillary muscle dysfunction and reflected at the bedside by an apical midsystolic murmur, usually grade 2.

tively frequent (up to 30% in some series)<sup>3,10</sup>. It is usually not symptomatic; when symptomatic, it is usually treated with relatively simple measures. Postural hypotension occurred in four of 20 patients (defined as a drop of 40/20 mm. Hg. in systolic/diastolic blood pressure). When symptomatic, it was readily controlled by wrapping the patient's legs and rarely by adding a long-acting alpha adrenergic agent to the regimen.

Ventricular arrhythmias, however, have life-threatening potential. Experience in coronary care units has shown that prompt recognition and treatment of ventricular irritability can reduce the mortality in that setting by as much as 50%.<sup>11</sup> Ours is not a postinfarct population. However, the concept of early recognition and treatment was applied. The use of the Avionics electrocardiograph makes this possible for ambulatory patients. The patient's VPC's were most often recognized initially on the 12-hour recording before they appeared on the electrocardiogram. A grading system was used and patients with more than ten VPC's per hour were treated. Studies in postinfarct populations using continuous electrocardiographic tape recordings have shown a correlation between the number of VPC's per hour and prognosis.<sup>12</sup>

Six of our 20 patients had an increase in cardiovascular symptoms or findings (other than postural hypotension) while on levodopa. In three patients (#3, #4, #15), angina increased. In two of these patients, it was quite clearly related to an increase in activity and as such cannot be specifically correlated with levodopa therapy. In one (#4) spontaneous angina occurred (it had been present before levodopa therapy

and controlled with vasodilators). One patient (#6) had a myocardial infarction and developed angina and VPC's when levodopa was later reinstituted. This is the only case in which levodopa was discontinued because of the patient's cardiovascular status. In two cases a significant number of VPC's developed (#3 and #14). With the exception of our patient who had an infarct and whose therapy was stopped, two of 20 patients (10%) developed "quantitatively significant" VPC's of greater than ten per hour. Kotler et al.<sup>12</sup> monitored 160 ambulatory postinfarct patients using a system similar to ours and found a significant increase in mortality when greater than ten VPC's per hour were recorded. Our own experience over the last several years is quite similar and, hence, greater than ten VPC's per hour was our quantitative criterion for significant VPC's.

It is important to note that our therapeutic approach was similar to that used by us in a nonparkinsonian population, i.e., quinidine sulfate therapy in usual doses. Beta adrenergic blocking agents were withheld for possibly refractory patients but their use was not necessary.

It is by no means certain that the arrhythmias previously described are due to levodopa therapy. When dealing with an elderly population with known cardiac disease (the average age in this study was 68 years), the natural history per se could be responsible for many of the "cardiac side effects" attributed to levodopa therapy. In a recent excellent two-year study of 100 patients with Parkinson's disease, Lee et al. came to a similar conclusion.<sup>13</sup> In fact, the incidence of arrhythmia in patients with Parkinson's disease

in the "pre-levodopa era" in one report<sup>14</sup> was greater than in the patients in our series treated with levodopa.

Several of the reported sudden deaths in patients taking levodopa<sup>13</sup> are undoubtedly due to arrhythmia. Whether or not the drug per se is related, there is little question that continuous ambulatory monitoring of selected patients will recognize, classify, and quantitate arrhythmia early so that appropriate treatment may be undertaken.

In patients with symptomatic cardiovascular disease, it seems reasonable to begin therapy slowly, to monitor the patient at least before and after the first and second week of therapy. Our criteria for symptomatic cardiac disease include unstable angina, failure, and arrhythmia.

It should be noted that the patients who had cardiovascular problems while on levodopa had symptomatic and active cardiac problems prior to treatment (all patients who had no cardiovascular abnormalities on levodopa were Functional Class I while only one of the five who had cardiovascular abnormalities on levodopa was Functional Class I).

It has been suggested that a tolerance to the cardiovascular effects of levodopa may develop.<sup>15</sup> However, the appearance time of most of the cardiovascular abnormalities in our study ranged from two weeks to six months after therapy was initiated, and occurred at dosages ranging from 1.25 to 3.0 gm./day. This later onset of cardiovascular complications of levodopa therapy has been observed in another recent study in which cardiovascular symptoms and complications occurred from six months to two years after treatment began.<sup>13</sup> It is our observation that patients with active cardiac disease are the ones who de-

velop problems and, hence, careful cardiac follow-up is imperative in this group.<sup>3</sup>

The fact that two of our patients had an increase in exertional angina as their capability to perform physical activities increased emphasizes the importance of a gradual resumption of such activities.

The results of our study are quite similar to those found by Hunter et al.<sup>5</sup> We would agree that the small risk of cardiac complications must be weighed against the improvement that commonly occurs during levodopa therapy in deciding whether to treat a particular patient.

### Acknowledgments

The authors wish to thank Dr. Clifford Joseph, Hoffman-La Roche, Inc., for his invaluable assistance throughout this study; Hoffman-La Roche, Inc., for supplying levodopa (Larodopa), as well as financial assistance; Mrs. Pamela Scherer and Rosemary Sherin for their technical contribution; Alan Abdulla and Howard Barron, medical students at the University of Miami, and Dr. Michael Coverman for their aid in screening and interpretation of the electrocardiographic scans and Mrs. Nancee Blum and Mary Ann Petzoldt for valuable secretarial assistance.

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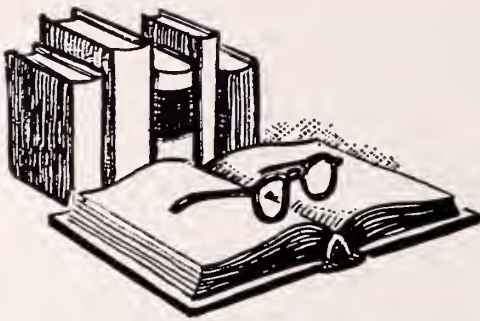
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► Dr. Gordon, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami 33152.

"Can you imagine any conditions more demoralizing than those welfare mothers live under? Imagine being confined all day every day in a room with falling plaster, inadequately heated in the winter and sweltering in the summer, without enough beds for the family, and with no sheets, the furniture falling apart, a bare bulb in the center of the room as the only light, with no hot water most of the time, plumbing that often does not work, with only the companionship of small children who are often hungry and always inadequately clothed—and, of course, the ever-present rats. To keep one's sanity under such circumstances is a major achievement, and to give children the love and discipline they need for healthy development is superhuman. If one were designing a system to produce alcoholism, crime and illegitimacy, he could not do better.

A quotation by Representative Griffiths from G. Y. Steiner's book, "The State of Welfare," describing a mother's life on welfare.





## Book Reviews

**The Care of Minor Hand Injuries** by Adrian E. Flatt, M.D. 293 Pp. 323 illustrations. Price \$21.50. St. Louis, The C. V. Mosby Company, 1972.

The whole idea of the book is to present in easy, understandable terms, the basic principles necessary in the more common injuries of the hand. This is taken in sections of anatomy, principles of care, surgical techniques, and then separated into the individual injuries.

The anatomy section, which borrows heavily from other workers, is excellent. It truly presents the anatomy of the hand in a manner understandable by those who do not see it often and are not forced to work with the hand as a surgical problem daily.

The principles of care are somewhat didactic, and are stated purposely, as such, feeling that complicated problems should be handled by a specialist in the field, but that everyone should know how to deal with emergencies if he should see them. Methods of anesthesia, use of dressings, and splints are discussed. Even a section on use of antibiotics in hands is brought forward.

His section on surgical techniques is quite good, with heavy emphasis placed on skin grafting. Care of tendon injuries, as well as vascular surgery, receive mention. Common methods of repair of pulp loss at the end of the finger is discussed, giving you multiple choices as to treatment of these amputations of the pulp. Amputations are discussed as to the bony and tendinous properties. Both the Kleinert and Kutler method of advancement grafting of the distal finger tuft are explained exceptionally simply so that they can be performed with understanding by the average surgeon. Joint injuries are discussed along with fixation, in which the author clearly feels that the internal fixation is best, and is a big advocate of Kirschner wire, when they are necessary. He makes only passing mention, however, of the Riordan Fixation Pin, which is making it considerably easier to do internal fixations in the average office or emergency ward. Burns are very

cleverly discussed and there is a very simple chapter on infections.

The overall format of the book is an excellent presentation. The scope is purposely limited so as not to be overwhelming and discouraging. The level is kept to that of the surgeon who does not see more than occasional hand injuries. Residents and interns will have much to gain from a book of this nature, and it should probably be part of the routine emergency room library. The technical qualities of the book, as far as drawing and illustrations, are unusually good. His x-ray reproduction is excellent.

JOEL P. KALLAN, M.D.  
MIAMI SHORES

**Current Concepts in Radiology** edited by E. James Potchen, M.D. Pp. 346. 502 Illustrations. Price \$24.75. St. Louis, The C. V. Mosby Company, 1972.

This book is a compilation by 19 contributors on 13 various subjects, explaining the radiological diagnosis of disease, with one chapter on the radioisotopic detection of tumors.

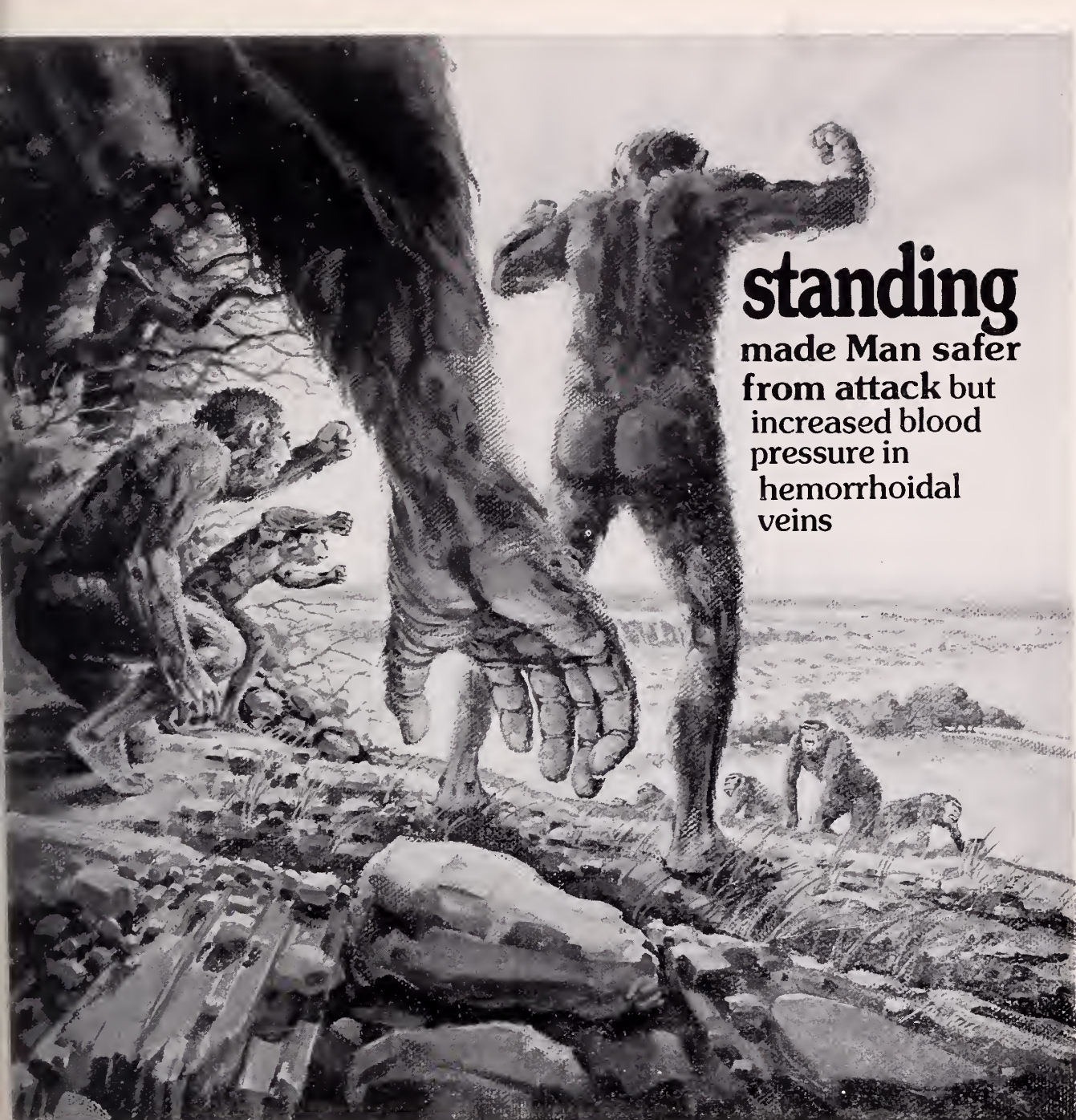
Actually, the book is a review of the major advances in diagnostic radiology in the past few years, and combines it into one heading or chapter for each pathological condition. Such a compilation is of great benefit for most radiologists because it brings together all the pertinent information that has been accumulated in recent years.

Admittedly, some of the selections are somewhat theoretical and difficult for the average radiologist to apply in his daily practice; however, the book would be quite helpful to radiologists in training and those who have just completed their training and are in the early stages of their practice.

The book is well bound, and is profusely illustrated with charts, reproductions of x-rays, etc.; however, the price of \$24.75 does appear to be rather steep even in this day of galloping inflation.

FLOYD K. HURT, M.D.  
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# The Problem-Oriented Medical Record

## Is There More Than Promise in PROMIS?

JACK W. FLEMING, M.D.

The problem-oriented system (PROMIS)\* devised by Lawrence Weed,<sup>1,2</sup> Professor of Medicine at the University of Vermont College of Medicine, is considered a real breakthrough. It includes the problem-oriented medical record (POMR), audit, education, computerization and utilization of paramedical personnel. POMR is an important foundation for the entire system. The American Society of Internal Medicine has endorsed the system and many medical schools are using it for improving patient care, teaching and research.<sup>3</sup>

Obviously the system appears desirable for institutional use but the clinician may question its feasibility in his own practice. Even if POMR's four main components are understood (Figs. 1-4) and the physician agrees that some parts of it might be feasible and helpful, inertia, mechanics and the feeling that "it can't be done unless everyone is doing it" prevents many from trying the system. Actually many practicing physicians are using it.

### Feasibility in Practice

In my opinion PROMIS offers more than lofty promises. I am not expert with POMR's technique nor totally consistent in its use but I believe it is feasible in medical practice. POMR requires some increase in initial investment of time, especially by the novice; however, much of this investment is repaid at a later patient visit and/or when the record is reviewed. Delegating parts of data gathering and record keeping, enhanced by the system, may even decrease the physician's time as he becomes skilled in its use.

A group, section or all staff members should undertake adoption of the system together. The individual physician can start it alone using standard history and physical forms in his office

or hospital for a data base and the usual progress notes. Two other standard progress note sheets can be used for "problem list" and "initial plan." Alternatively the initial plan can be recorded at the end of the data base on the same page.

### Implementation in the Community Hospitals

The problem oriented medical record (POMR) includes, basically: (1) The Data Base, (2) The PROBLEM LIST, (3) The Initial Plan, and (4) The Follow-Up (progress notes, flow sheets, discharge notes, etc.). These forms may be very sophisticated and as comprehensive as the physicians and hospitals want them to be. In order to begin the system in community hospitals where interest in using the POMR may vary widely, only simplified, basic new forms should be included on the chart. The current history and physical examination forms should be continued; all of the new forms are to be used voluntarily.

To begin a POMR: Continue use of current or old forms for: Data Base (History and Physical Examination) and Progress Notes. Add the following new basic forms: PROBLEM LIST—POMR-1; Temporary Problem List—POMR-2, and Initial Plan Sheet—POMR-3.

Optional: Flow Sheet—POMR-4 and Rx Sheet—POMR-5.

An individual can draft makeshift versions of all of these forms; however, maximum value of the POMR results from continuance and permanence of the PROBLEM LIST and consistency of the record. Thus, *three additional* sheets should be printed and appear on every hospital chart in order to make it possible for the system to succeed. Physicians and nurses may learn more about the POMR through observation and trial if these forms are integrated into the chart consistently.

Forms available:  
POMR-1 thru POMR-5 (Five one-page basic forms)  
Pfeiffer Printing Company—201 West Government Street—  
Pensacola, Florida 32501  
Systemedics (Cross & Bjorn)—more sophisticated forms  
Systemedics/AMS POMR Division—Princeton Air Research  
Park—P. O. Box 2000, Princeton, New Jersey 08540

\* "Problem-Oriented Medical Information System" installed with federal grant at the Medical Center Hospital of Vermont in Burlington.

## Data Base

The Data Base (Fig. 1) consists of the patient's profile or general information about him, chief complaints, present illness, past history, systems review and summary of basic laboratory studies. "Chief complaint" concisely states the reasons the patient sought medical attention. The main difference of the POMR format from the conventional "present illness" recording is the approach. Previously known diagnoses pertinent to the present illness and symptoms or syndromes are listed in the POMR as separate problems, and each problem has subjective and objective comments. "Subjective" provides complaints and descriptions by the patient, and "objective" includes reports of previous tests and observations which may be pertinent to the problem. Previous treatment and important responses are subjective if the patient provides the information and objective when this information is obtained from medical records or other sources.

The data base content may be as comprehensive as the physician chooses; however, the basic criteria suitable for the type of evaluation should be defined or decided in advance. The defined data base acceptable to the gynecologist usually will be quite different from the cardiologist's. Utilization of patient questionnaires and assistance from aids can expand capabilities of developing a structured and relevant record.

### DATA BASE

Patient Profile	.....
Chief Complaint	.....
History of Present Illness	.....
Subj.: Pt. described pain	.....
in joints . . . Rx	.....
Obj.: . . . (or Rx)	.....
Other problems	.....
Hypertension	.....
S	.....
O	.....
Past Medical History	.....
Family History	.....
Systems Review	.....
Physical Examination	.....
Laboratory Data	.....
CBC	.....
Basic Chemistry	.....
Urinalysis	.....
Chest X-ray	.....
EKG	.....

Fig. 1—Sample structures of Data Base for problem-oriented medical record.

### Problem List

The Problem List (Fig. 2) is a permanent part of the medical record. The same sheet always is placed on the front of the chart. Brief or insignificant problems are not included. These are listed as temporary problems in the progress notes

## PROBLEM LIST

Date of Entry	ACTIVE	Date Resol.	INACTIVE
1/2/69	#1 Arthritis → R.A. (1/11/69)		
9/9/69	#2 Hypertension		
	#3 (1953)		Appendect.
4/6/70	#4 Weight loss, Path → 2° to #5		
8/5/70	#5 Hyperthyroidism (1971)		
5/6/71	#6 Angina → ASHD		
	a. CHF		
	b. Dysrhythmia		
8/2/72	#7 Anxiety reaction		
8/2/72	#8 Child has chronic nephritis		
Problems included may be:			
1. Medical problem:			
a. Highly resolved problem			
b. Physiological abnormality			
c. Symptom or physical finding			
d. Laboratory abnormality			
2. Psychiatric			
3. Socioeconomic			
4. Demographic			

Fig. 2—Sample structure of problem list for problem-oriented medical record.

and in the temporary problem list. Significant problems entered on the problem list include (1) medical problems: highly resolved problems previously referred to as a "diagnosis," or poorly resolved problems such as a physiological abnormality, symptom, physical finding or laboratory abnormality; (2) psychiatric problems; (3) socioeconomic problems, and (4) demographic problems (lives alone, health hazards).<sup>2</sup>

Developing meaningful entries for the problem list is one of the most difficult and important features of the system. Each problem is numbered and titled. The number is reserved thereafter for the same problem when it is considered on the patient orders, initial plans, progress notes, consultation notes, and discharge summaries of the current and future charts.

The list becomes cluttered and less meaningful if all problems are entered. It is extremely helpful to keep a temporary problem list. If the temporary problem persists longer than 48 hours in the hospital, it may be related to other problems and/or entered directly in the problem list. Temporary problems may be designated A, B, etc. This list should follow directly the problem list in the Chart. Nurses as well as physicians may make entries on the list in the hospital.

Cross and Bjorn<sup>1</sup> recommend a temporary problem list for brief illnesses or health problems of less than a few weeks duration in their outpatient records. These problems may be entered in



the problem list if they become recurrent or otherwise significant.

Initial Plan

The Initial Plan (Fig. 3) lists problems on the left and plans on the right of a separate sheet of paper. Each problem is treated separately; for example, the patient may have two problems, arthritis and hypertension. Each problem has corresponding plans. Under each plan, three parts are listed consistently: Diagnostic (Dx)—plans for further studies; Therapeutic (Rx)—plans for treatment, and Education of Patient (Ed)—plans for advice and education to be communicated to the patient. Some physicians use data base (DB) for diagnostic; diet, drug, activity (DDA) for therapeutic, and PTED for education of patient.

“Rule Outs” (RO) are important parts of the initial plan indicating the clinician’s approach to problems at various levels of resolution.

Follow-up in the POMR includes narrative progress notes, flow sheets and utilization of feed back from these to the defined data base.

INITIAL PLAN

Admission Note: (A brief handwritten or typed note may be entered here as the admission note on the first sheet of the progress notes.)

PROBLEMS	PLANS: Dx-Rx-Ed
Arthritis	
Prob. R.A.	Dx — R.A.; sed rate
R.O. L.E.	ANA, L.E.
	Rx — ASA
	Ed. — Pt. to be advised
Hypertension	Dx
	Rx
	Ed

Fig. 3—Sample structure of initial plan for problem-oriented medical record.

Progress Notes

In the narrative Progress Notes (Fig. 4) each problem is numbered and titled and structured so there is a consistent order of display: subjective (S), objective (O), assessment (A), and plan (P). Under each plan are listed the sections: Diagnostic (Dx), Therapeutic (Rx), and Education of Patient (Ed). One of several problems may be mentioned one day and different problems the next. Under a problem the progress notes may state only objective findings and under another only new subjective statements by the patient. This system is flexible but at the same time specific, graphic, and consistent.

POMR flow sheets have been constructed for general laboratory data and various chronic problems including arthritis, cardiovascular disease, diabetes mellitus, and leukemia.

PROGRESS NOTES

#1	Arthritis
S	Pt. says
O	Joints show
	R.A. test is positive
	L.E. is negative
A	Rheumatoid arthritis, improving
P	DX Repeat Sed rate
	Rx
	Ed
#2	Hi B.P.
O	160/100 rt. arm sitting, see flow sheet
A	Essential hypertension, stable
P	Rx Hydrochlorothiazide 25 mg q.a.m.

Fig. 4—Sample structure of progress notes for a problem-oriented medical record.

Discharge Summary

In the Discharge Summary (Fig. 5) all problems dealt with during hospitalization are listed by number and title. An admission statement briefly summarizes the reasons for and circumstances of the admission.

DISCHARGE SUMMARY

Problems	
#1	Rheumatoid arthritis
#2	Hypertensive C.V.D.
#6	Hyperthyroidism
Admission statement: 49 year old	
of 2 mos. duration	
#1	Rheumatoid arthritis
S	
O	P.E., Lab., X-ray
	Course in hospital and consultations
	Treatment
A	
P	
	Dx
	Rx
	Ed.
#2	Hypertensive C.V.D.
S	
O	
A	
P	
#6	Hyperthyroidism
S	
O	
A	
P	

Fig. 5—Sample structure of discharge summary for problem-oriented medical record.

Subsequently under each problem is listed the pertinent subjective history, objective physical, laboratory and x-ray findings and hospital course, assessment, and plans.

The Consultation Note structure is described in Figure 6.

CONSULTATION NOTES

Please evaluate for joint pains and high blood pressure.

J.D., M.D.

#1 Arthritis

#2 Hypertension

#1 Arthritis (Assessment)

Principal recommendations (Dx Rx Ed)

Discussion supporting above

Identification of new problems cough for 14 mos.

#9 Chronic Cough

S

O

A

P

Dx

Rx

Ed.

Fig. 6—Sample structure of consultation notes for problem-oriented medical record.

Tying Hospital and Office  
Records Together

One difficulty is tying hospital and office records together, especially when patients see several physicians in separate offices and several hospitals. With PROMIS the problem list sheet may be duplicated from either hospital or office, exchanged and brought up-to-date.

Ideally the patient should have one permanent problem list used by all physicians treating him. This is an important, difficult goal, but physicians should try to coordinate and relate their office and clinic lists to the hospital list. Some physicians give the patient a copy of the problem list.<sup>5</sup> This has advantages and disadvantages. A copying process can reduce the list to wallet card size. This copy and other data carried by the patient can be of great value to patient care in a mobile population. Also available is a wallet-size "health tag"\* with emergency medical information and

\*Systemedics, Inc., Princeton Air Research Park, Princeton, N. J. 08540.

frames for microfilms of a most recent data base as well as the problem list. It is conceivable that computerization of a permanent problem list will assist in continuity of care.

Audit, Patient Care Appraisal  
and Quality Assurance

Audit of medical records long has been a function of the hospital medical staff. In recent years the importance has been emphasized of the intermeshing relationship between audit of the record, patient care and continuing education.<sup>6,8</sup> We have missed these points too often and stopped short of educational opportunities by auditing for audit's sake.

Stressing the educational advantages of audit, the AMA and many state medical associations<sup>7,9</sup> have developed programs similar to the Washington State Medical Association's Patient Care Appraisal Education Program,<sup>9</sup> a form of staff or group nonthreatening audit determined by local criteria. The result is correction of deficiencies by pertinent staff educational programs.

A nonthreatening audit may be accomplished by different approaches but the POMR is a tool which makes group and individual audit easier and more pertinent. Audit is a fundamental component of the problem-oriented system. Through audit, deficiencies can be determined more easily and corrected by appropriate educational efforts.

POMR—Is It Worth the Effort?

Some physicians may have had a question similar to mine after hearing about the problem-oriented medical record and PROMIS. It sounds worthwhile, but is it too time consuming in the busy practice world? Yet, I was curious enough to try if for no other reason than to determine for myself why so many people were excited about the system.

You may approach the question in a problem-oriented manner: obtain more subjective and objective data, and assess the feasibility and desirability of POMR and PROMIS in your own practice. Then set up your own diagnostic, therapeutic and educational plans for learning more about and utilizing the problem-oriented system.

References are available from the author upon request.

► Dr. Fleming, 1750 North Palafox Street, Pensacola 32501.

# The Industrial Physician

JOHN H. MITCHELL, M.D.

The industrial physician is a peculiar product of the medical profession. The fact that he may have had an outstanding career as a surgeon, internist, orthopedist or other specialist does not necessarily indicate that his efforts in industrial practice will be similarly remarkable. Previously his primary and sole concern was the patient, then the patient's family. In industrial practice the patient still is foremost, then his family, but added is responsibility to the plant foreman, employee supervisor, personnel department of the company, insurance carrier, and the Industrial Commission. The industrial physician is expected to arrive at an accurate diagnosis when the patient first presents himself and be prepared to give an estimate of the length of time the employee will be off work—an absolute impossibility except in a few instances.

The industrial physician takes patients as they come, when they come. Accidents do not occur by appointment, only examinations. He keeps voluminous records readily available, maintains elaborate equipment and a highly trained staff. Without the equipment and the staff many patients would have to be directed to the hospital, thus delaying treatment in some cases and increasing the cost. He expedites the flow of patients as much as possible, aware that the man who waits, the driver and truck that brought him to the clinic are adding to the cost of doing business.

## Physical Examinations

Much of the industrial physician's time is taken up with examinations of one kind or other—preemployment, periodic and return-to-work.

In some respects the preemployment examination is an enigma. It is not conducted for the sole benefit of the job applicant; yet, as a preventive procedure it may uncover an abnormality he did not know existed. Then he can be encouraged to have it corrected before more serious problems result.

The examination may block employment of the person who is handicapped, yet already accepted for the job by the company's personnel department. Realizing this he may attempt to cover it

up; thus causing the physician to become a sort of medical detective. Frequently he may be antagonistic and resentful and if a major defect is found he may become downright belligerent. The handicap may not necessarily mean outright rejection for the job but possibly the recommendation for duties other than those for which he is being considered. Prior to the examination the doctor must learn specifically what is expected of the employee. Then after evaluating the physical findings he is better able to decide whether the handicapped person should be permitted to work at that particular job.

The law requires the employer to have knowledge of a preexisting condition and the best means to obtain it is a thorough preemployment evaluation. It presents the physician with a tough assignment, and sentiment and sympathy cannot be permitted to overrule the facts.

The conscientious physician cannot issue an Interstate Commerce Commission card to the individual with poor vision not corrected or correctable with glasses, to one who is colorblind or hypertensive or a diabetic who takes insulin. He cannot approve the postcoronary patient for hard physical labor or the crane operator who has poor depth perception or slow cerebration. There is a place in the workforce for everyone but they must be properly situated for their own protection and for the protection of their fellow workers.

The periodic physical examination is useful in detecting disabilities before they become serious. When a defect is found the patient can be referred to his personal physician for treatment. We do not treat personal patients.

In the return-to-work physical the opinion of the industrial physician frequently conflicts with that of the patient's personal physician. In order to perform the duties entrusted to him in the most satisfactory manner, the company physician must be reasonably familiar with the operation of the business and the duties of employees. The personal physician may not be familiar with the work requirements of the patient who is anxious to return to work and "thinks he can make it."

During any physical examination the physician should observe the patient's arms for needle

This article is a condensation of the address, "The Role of the Industrial Surgeon in Industry," presented to the Southern Safety Congress, March 6, 1972 at Jacksonville.



punctures and in the presence of suspicious marks, the legs also. The past several months physicians in our group have detected at least one such patient a week in preemployment examinations. Each one has been handled individually; there are no established procedures. If we believed the patient no longer was taking drugs, we contacted the prospective employer by telephone. Usually most will give him a chance provided he reports to us at intervals for follow-up observations.

### Injuries

On-the-job injuries are, of course, the principal reason for maintaining the services of the industrial physician and are also the source of most problems. The employee drops a box on his foot through his own carelessness. He does not blame himself, however, he blames the company. The foreman sends him to the company physician; he is angry when he comes in the door. He wanted to go to his own doctor. Thus arises a conflict of personalities. If it cannot be overcome and the patient convinced he is being handled properly a change of physicians should be recommended. Already the pattern has been established. The industrial physician often refers the injured patient to a specialist for consultation and/or treatment. He has no desire to jeopardize the patient's wellbeing.

Moonlighting presents a major problem. The man who works 30-35 hours a week may hold a second job. When he gets hurt on job number two, is he marked "off work" on it and "work" on job number one? Unless the accident is serious he will want to continue working at one or the other.

Another problem is getting the employee back to work who has no incentive to go back. Treatment of the injury has produced good results and the doctor-patient relationship has been satisfactory. Now this is thrown aside and he has an entirely different outlook. His income has been as much or more than his take home pay. A policy has made the car payment; another the house payment, also one or two personal accident policies will pay as long as he is off work—all this tax free.

The patient who thinks he has bone injury will not return to work until convinced otherwise. If this problem can be solved by x-ray examination, even though the physician knows it is not needed, everyone gains. In our practice we show

the x-ray to the patient. He appreciates it and it helps him to understand why the injury is still painful. Also we frequently make films when the patient has been x-rayed elsewhere. Treatment is our responsibility and misinterpretation always is possible.

When the injury does not fully respond to the best possible treatment, the result may be a permanent partial disability which must be rated by the industrial physician. There is no problem if the disability is listed in the Workman's Compensation Law. It may be a good idea to refer the patient to another physician for his opinion. Seldom is the patient with a permanent partial disability satisfied with the remuneration he receives from the insurance carrier.

### Public Liability Accidents

In dealing with these patients the physician should ascertain if the purported injury did indeed occur. He should obtain as much information and as many witnesses as possible, bearing in mind that many of them are professionals and have been involved in many "falls" at different locations. An insurance adjuster documented one person with 30-plus falls. Unless there are objective signs of injury such as a bruise, discolored area, laceration or abrasion the physician must convince himself that the person really is injured. If so the pain must be alleviated and the damage repaired to the best of the physician's ability. He must be kind, sympathetic, understanding and gentle.

### Conclusion

Industrial medicine is a difficult specialty frequently misunderstood or misjudged, to say the least. But the patient, not the company, comes first and his well-being is foremost in all examinations and treatment. As in private practice, each one is unique, even though the problem may be similar. Whether a preemployment, periodic or return-to-work physical, public liability accident evaluation or treatment of an on-the-job injury, it must be analyzed carefully and managed in a manner specifically adapted to that patient. There are no stereotyped procedures. As for the problems, without them life would be nondescript indeed; without efforts toward solving them, it would be bland.

► Dr. Mitchell, 241 West Ashley Street, Jacksonville 32202.



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**\*Indication**

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

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# **Sporostacin<sup>Trademark</sup> Cream** (chlordantoin 1% and benzalkonium chloride 0.05%)

**Contraindications:** None known.

**Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued.

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**Supplied:** SPOROSTACIN Cream is available in 3.35 oz. (95g) tubes with the ORTHO<sup>®</sup> Measured-Dose Applicator.

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## Editorials

### What is a Medical Record?

Lawrence L. Weed, Professor of Medicine at the University of Vermont College of Medicine is the originator of a new system of composing patient's records, saying that medicine is out of control because of chaotic bookkeeping. Called an assault on tradition, health planners hail it as a tool for practice audit whereby doctors and their peers can set their own standards and criteria. Developed by Dr. Weed, described elsewhere in this issue of the Journal, the "Problem-Oriented Record," an inverted image of the source-oriented record now commonly in use, is a chronicle of clinical practice that divides medical action into four parts. There is a carefully defined, standardized data base including chief complaint, present illness, patient profile, review of systems, physical examination and laboratory reports. Next, follows a numbered and titled list of every problem the patient has ever had. This serves as an index or table of contents. Following this is a plan of treatment for each problem, including management, additional work-up and therapy. At the end are progress notes, written as subjective and objective complaints, interpretation, and plans for further care, each labeled according to each problem. A major change, allegedly, is that each problem-oriented chart, readily adaptable to computers, defines and preserves the doctor's logic to be understood by everyone, so that any future physician seeing the same patient is given a road map to analyze and treat new problems.

Including the care of the individual patient, the medical record functions for administrative claims purposes, provides for peer review, retrospective analysis, postgraduate education, physician to physician communication, directions

to nurses and others as well as protection against legal action. The record is a kind of rearview mirror for physician performance, being beneficial primarily to the physician who writes the record but also to any physician who sees the patient in the future.

One of the values of the Weed system lies in its potential as a teaching aid for medical students, helping them to think constructively about keeping records and at the same time, providing them with a framework to develop their own solutions to the problems of record keeping.

The Weed system, the computer desk terminal, the automated data gathering programs, all offer opportunities for more complete and accurate, as well as more quickly retrievable, medical records. Efficiency in keeping medical records, however, does not just mean saving time and none of the above should be accepted as a final solution. More efforts should be sought to adopt any new system to a variety of practical situations. The mere fact that the Weed system has gained such notoriety is evidence of the concern of physicians, being deluged by increasing paper work, that newer methods must be found. Undoubtedly the practitioner who has been out of school more than ten years will resist efforts to re-educate himself to any new system, so current evangelical efforts must prove that the system is an aid to patient care without taking up more of the doctor's time.

Record keeping devours valuable physician time and limits patient contact opportunities, so constructive steps must be taken to influence third parties to adopt more realistic requirements



for obtaining the data they want from physicians. Automated data and computer storage would provide these agencies with easy access to pertinent information. If a comprehensive system of medical records were developed to include those of office patients, surveys of diagnosis and treatment problems would be conducted on a profession-wide basis using the computerized data. Maintaining privileged information confidential and protecting the physician from unjust criticism are fears that come to mind.

The medical record has undergone a radical change in the last 100 years. The Weed system offers an innovative comprehensive alteration as a solution of this problem. If given the choice, most doctors would prefer concentrating on the art of medicine but realizing that good medical care is based on good records, would like to improve their record keeping as well. If this could be efficiently accomplished, all would benefit.

C.M.C.

## Priorities

The present national administration has declared that economy in government is required; a balanced budget is the goal. This is certainly admirable and desirable, particularly since some of the largest deficits in recent years have occurred during its first term. This economy drive may seem somewhat incongruous coming from the executive who spent the largest sum in our history on his own second inauguration. As further evidence of his determination to cut costs, \$37 million has been requested for 17 new helicopters to ferry visiting dignitaries to and from the rear lawn of the White House. One can hardly bear the thought of the inconvenience and discomfort that would occur if these people had to be transported in luxury cars. This tight-fisted regime wants cutbacks in Medicare benefits while asking funds to reconstruct North Viet Nam. As Alice in Wonderland said: "Things get curiöser and curiöser."

The Office of Management and Budget has directed abolition of a number of medical programs. These include the Hill-Burton Program, the Regional Medical Programs, and the NIH Programs of support for training of research scientists. Further reductions are contemplated in the programs for Community Mental Health, Children's Mental Health, and programs dealing with alcoholism. Support for education of ancillary health personnel such as nurses, pharmacists, and public health workers will be curtailed.

These programs were instituted in good faith because a need was believed to exist. One cannot disagree with the concept of re-evaluating ongoing programs and discarding or modifying those having served their purpose or those having failed to be productive. It can be argued that Hill-Burton has completed its job of providing funds for hospital construction. Other programs have been less successful in toto although certain phases have been rewarding; the Regional Medical Program might fall in this category. The NIH Training and Fellowship Programs for research scientists has worked well. The majority of the young faculty members in medical schools today are products of these programs, and much of the teaching in medical schools today is done by these graduates. Obviously, the future leaders of academic medicine will come from this group.

The funds previously used for this latter program will be diverted to the PSRO organizations. I cannot help but think that the money would be better spent in education. In a recent article in the JAMA, the experience with the PSRO in Illinois was detailed. The flow chart looked like a maze used to test drunken rats. While emphasizing the savings that resulted, the article tended to minimize the administrative costs. It is the nature of the beast that the latter costs will tend to stay constant or more likely rise while the potential savings level off and then drop as the "corrective measures" that have been in-

stituted result in diminishing returns with the passage of time.

Congressman Paul Rogers (D.Fla.) has introduced legislation (H.R. 5640) requiring further funding of this research training program. This bill warrants your thoughtful consideration and support. While the TOWN might consider this legislation solely for the benefit of the GOWN, this artificial dichotomy of the medical profession must be avoided. The fate of this program—whether it is continued or discarded—will have a lasting effect on the training of the future members of the medical profession. The scientific progress made in this country needs no defense. It stands on its own record. To tamper with its basic training program should be done only with

great reluctance. The administration has suggested a four fold increase in the funds for cancer research to \$445 million and a tenfold increase to \$250 million in the appropriations for research on heart and lung disease. Funding the programs without providing the trained personnel to staff them is self defeating.

When the cry for economy arises, it gives rise to the old goring of whose bull syndrome. It is human nature to favor cutting costs as long as the other fellow's funds are involved. In this instance, in my opinion, the ultimate loser will be the country if this penny wise, pound foolish economy move is carried out.

R.T.D.

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# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis or parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of Ascaris in the mouth and nose. Hypersensitivity reactions



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Include: fever, facial flush, chills, conjunctival injection,  
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Applied: Chewable tablets, containing 500 mg thiabendazole,  
boxes of 36, strip packaged, individually foil wrapped;  
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bottles of 120 ml.

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tive or see full prescribing information. Merck Sharp &  
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## INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	1/2
50	0.5	1
75	0.75	1 1/2
100	1.0	2
125	1.25	2 1/2
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



## ORGANIZATION



JOSEPH C. VON THRON, M.D.

# Joseph Cangney Von Thron, M.D.

## Our 97th President

When the young first mate of a large merchant ship directed its course across the shallow Grand Bahama Bank, it was a fortunate circumstance that provided an unusually high tide, lifting the hull above the many reefs and dangers. It may be that this stint at the helm was prophetic of a new type of helmsmanship more recently acquired. Yes, Dr. Joseph VonThron himself was the young mate and, as he laughingly relates this story of danger and good fortune, it is apparent that he has matured much in the years that followed. With helmsmanship like this, who can question that the Florida Medical Association will be guided to a great year?

Dr. VonThron was a native of Ohio, but was, by an odd coincidence, born in Orlando, Florida on December 1, 1926. His family returned to Port Clinton, Ohio, their permanent home, after a protracted business stay in Orlando. Young Joseph attended grammar and high school there and later attended college at the United States Merchant Marine Academy. It is in that institution, no doubt, that Joe acquired his excellent sense of direction which was later to carry him across the Banks, and subsequently to his currently enjoyed success as a physician, not to mention his unerring aim on the golf course.

In 1950, Joe was awarded a Bachelor of Science degree by Ohio State University, his second, having received such a degree from the Academy. Following up on this, Joe attended medical school at Ohio State, where he received the degree of Doctor of Medicine, June 11, 1954. After satisfactorily serving an internship at the University of Miami Hospital, he began the general practice of medicine in Cocoa Beach, Florida, where he continues to serve in a highly acceptable manner.

Dr. VonThron has been a Fellow of the American Academy of General Practice since March 1962, serving as president of the Florida society during the year 1969-1970. He holds a Charter Member's Certificate issued by the American Board of Family Practice. He served on the Board of the Cape Canaveral Hospital during its formative years and gave much of himself in helping bring this dream to fruition. He served as President of the Medical Staff of

Cape Canaveral Hospital and in 1962 as President of the Brevard County Medical Society. Joe has served many years as a Director of Blue Shield and has given much time and effort in his studies of legislation related to our professional activities. He was engaged in solving problems for the physicians of Florida at a time when most of us weren't even aware we had problems. He has served with distinction in all of these positions and it seems that he is highly deserving of this current honor bestowed upon him by his colleagues over the State of Florida.

Now that we have looked at the physician, let us take a brief look at the man, the father, the neighbor, one of the boys! With all the attention he has given to his profession, Joe's first love remains his family and he spends much time at home engaged in family activities. It is no coincidence that sports plays a big part in the life of this man and his entire family. His gracious wife, Jane, aside from being active in Auxiliary matters, is an excellent golfer. She spends much time in spreading happiness and pleasure among all the people she knows, in a thousand ways, and still has time to advise and participate in Joe's medical society life. Jimmy and Judy are also excellent golfers; Jimmy has teamed up with Joe in numerous Father and Son matches. John is also developing a game and we still have to wait to see if Joan will follow in the family footsteps. John will be playing in the Father and Son matches this year as well as catching at Little League ball, and Judy has to divide her time between golf and cheerleading. Joe, himself, sports a handicap of 5, and in 1969, won the Perry Como Tournament.

In addition to his many other commitments, Joe has found time for many civic activities, having served as Chairman of the Board of United National Bank, and as president of the local Kiwanis Club in 1963. He found time to take Jim and Judy on a trip to Russia and to the Mexican Olympics, and, after all this, has managed to find time to be simply a great guy!

Now, isn't this the right kind of a fellow to have at the helm for the next year?

William H. Hyden, M.D.  
Cocoa Beach



# FMA 99th Annual Meeting

May 9-13, 1973

The final session of the House of Delegates of the 99th Annual Meeting of the Florida Medical Association closed with the benediction by Jack Cleveland. Shortly before this, delegates had watched Joe Von Thron present a portrait of Bill Dean to Mrs. Dean, accompanied to the podium by her two children. The third session, Sunday, May 13th, saw the culmination of a prolonged county society campaign for President-Elect in which Thad Moseley of Duval emerged as winner. Following the announcement, Merrill Wilhoit of Pensacola went to the microphone and asked the speaker to make the vote unanimous for Dr. Moseley. Fred Andrews from Mt. Dora became our new Vice President. The incumbents of all other offices were re-elected unopposed. This included the Speaker, Franklin Evans; Vice Speaker Lou Murray, and Jim Walker, Secretary-Treasurer. Also re-elected were the delegates and alternates to the AMA whose terms run from January 1, 1974 to December 31, 1975. These are Bob Zellner, Jim Cook, Burns Dobbins, Gene Peek, Rufus Broadway and Byron Thames. Announcing Ray Murphy, Irving Essrig and Jerry Schiebler as new Council Chairmen, Joe Von Thron pledged his efforts to do everything in his ability to further the best interest of Florida medicine. It was announced that Jerry Cox won the golf tournament aided by a hole in one on the 14th green. Earlier that morning a resolution on PSRO, (Public Law 92-603 which purports to see that medical care is needed, appropriate, efficient and reasonable), initiated some controversial debate. In describing his distaste for federal intervention, Dr. Walter Hamilton asked that the FMA proceed slowly in any kind of contract, advocating no relations with the federal government. Supporting him, Tom Quehl, labeled the

law as vague and unconstitutional. After some time, the House passed a recommendation for the establishment at the earliest possible date of the Florida Professional Standards Review Organization, Inc. This organization is to file an application with the Department of HEW as PSRO to serve as a prime contractor for the State of Florida, providing all statistical computer and support services to and for not less than twelve local PSRO's. This is to provide our local review and professional services.

After some discussion the House appeared to be opposed to the mandatory "certificate of need" for tax-supported health facilities. The House reaffirmed its confidence in the Board of Directors and employees of Blue Shield, urging them to continue to guard the interests of the physicians of Florida as well as those of its subscribers. A watered-down resolution that the relative value committee re-evaluate the surgical schedule was passed.

A drenching rain postponed the first session of the House of Delegates 30 minutes on Wednesday, May 9th, when Speaker Franklin J. Evans called Dr. William C. Roberts to open the session with an invocation. A quorum was declared present and the adoption of the minutes of the 1972 meeting was approved. Dr. William Dean gave an inspiring President's Address which will be published in the July Journal. Reference Committee personnel were announced, their chairmen being William M. Straight, Charles F. Tate, William W. Thompson, Frank C. Coleman and Miles J. Bielek. Earl D. Hadlow, President of the Florida Bar Association, addressed the members saying that we should work to eradicate smoking, alcoholism and defensive medicine brought on by fear of liability suits.

The A. H. Robins Award for Outstanding Community Service by a Physician was given to Sanford A. Mullen from Jacksonville, who got there by way of Tampa. The long list of his endeavors adds support to the old adage that the way to get something done is give the job to a busy man.

Thursday morning, the annual meeting of the Blue Shield was well attended. Dr. Zellner, chairman, gave his annual report. Following this on Thursday morning, the reference committees, giving any FMA member who attended, the opportunity to appear, to talk and to learn, met and discussed from every angle all the reports and resolutions referred to them. The committees included Health and Education; Public Policy; Finance and Administration; Legislation and Miscellaneous, and Medical Economics. Reference Committee 5, under Dr. Bielek, as usual having more controversial subjects, accomplished much at its initial meeting by sitting from 10 in the morning until 5 that afternoon.

The Women's Auxiliary to the FMA met the same day and at a luncheon presented awards and ribbons to the winners of the Auxiliary Art Show which displayed many varied and lovely works. Mary Ann Mathews of Jacksonville was installed as their new president. At the Women's Auxiliary FLAMPAC luncheon on Friday, Senator John Goodwin Tower was introduced as the only enlisted reservist in Congress and the first Republican elected from Texas to the Senate since 1870. He said that the United States enjoys the best medical care in the world and the less the government tampers with it, the better it will be.

At the General Session on Friday morning, Russell B. Roth, President-Elect of the AMA, spoke at the Abel Baldwin Memorial Lecture, saying the basic questions that medicine must answer are: Is there a health crisis? If so, is it in the quality, the quantity or the cost of medical care? And somehow we must devise a method to prevent being compelled to systematize medical care. He further said the AMA does not defend the status quo but is one of the more progressive organizations because of its members and its size.

The distinguished Layman Award was presented to the Honorable Verle A. Pope, who was too ill to attend.

At the second session of the House on Saturday, May 12th, there appeared a recommendation that regulations of the effectiveness or safety of drugs be placed in nongovernmental organizations. The delegates advised the FMA to encourage voluntary screening but oppose mandatory screening of sickle cell patients. Tabled was a resolution from Lee County attempting to set up statewide standards for associating with osteopathic physicians.

Howard DuBose, reporting Reference Committee 3 for William Thompson, obtained support from the delegates for a plan to raise the Bureau of Crippled Children to division level in the Department of Health and Rehabilitative Services and placing the Child Health Section at bureau level in the Division of Health.

William M. Straight was given the Certificate of Appreciation for the many years he has worked on the history of Florida medicine. He displayed additional talents while serving as a reference committee chairman during the meeting.

At the President's reception, Bill and Polly Dean greeted their many friends who were high in praise of his leadership during the year 1972-1973. As usual Gene Peek had on the most colorful coat but Sam Day out topped everyone with his Afro. The ladies all looked lovely while each delegate had so many ribbons on his badge that he would have outshone a South American General.

If you did not attend any of the meetings you missed an opportunity to see how hard your delegates were working in your behalf and you will be less informed of the many facets of the non-medical affairs affecting you and your practice. If you are interested, attend your county medical society meeting, seek out your delegate and quiz him, or, read the July issue of the Journal in which the proceedings of the 99th House of Delegates will be printed.

---

**You won't want to miss the 100th Annual Meeting of the Florida Medical Association. Special centennial program planned.**

**Diplomat Hotel, May 8-12, 1974, Hollywood**

## Medical News

### Southern Ob.-Gyn. Seminar

The 19th Annual Southern Ob.-Gyn. Seminar will be held at Asheville, N.C., July 22-27.

Information may be obtained from George T. Schneider, M.D., 1514 Jefferson Highway, New Orleans, La. 70121.

### ACR Admits 3 State M.D.'s

Three South Florida physicians were admitted as Fellows of the American College of Radiology during the College's 50th Annual Meeting in San Francisco.

They are Robert H. Nickau, M.D., of Tequesta; Mario M. Vuksanovic, M.D., of Coral Gables, and Robert F. Feltman, M.D., of Miami. All are members of the Florida Medical Association.

### Dr. Coleman Gets AMA Post

Francis C. Coleman, M.D., of Tampa, is the new Chairman of the AMA's Council on Health Manpower. He succeeds Malcolm C. Todd, M.D., of California, who served the maximum of two years at the head of the Council.

### Medical Directory Warning

The American Medical Association has advised county medical societies that interests in Miami are trying to obtain membership rosters, supposedly for the purpose of compiling a directory of physicians.

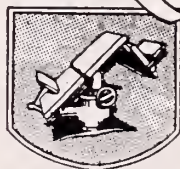
The "U.S. Medical Directory," of Miami has been asking county societies for these lists, and the AMA advises that they not be provided. Last year, "U.S. Medical Directory" offered physicians listings for \$10 apiece. The solicitations were designed to look like invoices.

"U.S. Medical Directory" is not to be confused with the AMA's *American Medical Directory*, which lists all physicians in the country at no charge.

J. Jerry Slade  
E. Stewart Irwin  
G. Robert Garrett  
Philip D. Diuguid  
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Fifty-Six Years in Florida

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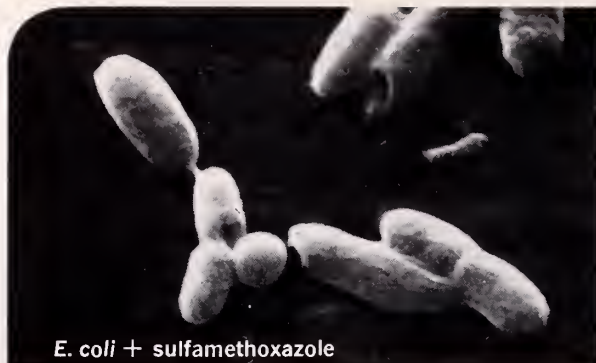
# Encounter under the Scanning Electron Microscope



## SEM reveals changes in *E. coli* exposed to antibacterial agents

The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in

detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.



*E. coli* + sulfamethoxazole



*E. coli* + tetracycline



*E. coli* + cephalothin



*E. coli* + ampicillin

## Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,<sup>1,3</sup> strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of

its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

It should be noted that no clinical conclusions can be drawn from this study, as it is not always possible to extrapolate *in vitro* data to humans.

**References:** 1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971. 2. Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother.*, 1:164, 1972. 3. Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been estab-

lished. Sulfonamides should not be used for group A hemolytic streptococcal infections and will not eradicate prevent sequelae (rheumatic fever, glomerulonephritis) of infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** Blood dyscrasias (agranulocytosis)



# Encounter in Clinical Practice

## Control of primary bacterial offenders

Antibacterial Gantanol® (sulfamethoxazole) controls susceptible strains of *E. coli* and other gram-negative and gram-positive organisms

often implicated in acute nonobstructed pyelonephritis and cystitis.

## Prompt antibacterial blood and urine levels

In from 2 to 3 hours after the initial 2-Gm adult dose, antibacterial levels are present in

both the blood and urine.

## B.I.D./T.I.D. dosage for around-the-clock coverage

Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8 h. dosage regimen. Either schedule provides coverage during the waking

and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

## Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often re-

spond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents including sulfonamides, especially in chronic or recurrent u.t.i.

## Your Option: Tablets or Suspension

Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide

therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

**In nonobstructed cystitis and pyelonephritis due to susceptible organisms**

**Gantanol<sup>®</sup>**  
**(sulfamethoxazole)**  
**Basic Therapy**

stic anemia, thrombocytopenia, leukopenia, hemolytic ane-  
purpura, hypoprothrombinemia and methemoglobinemia);  
gic reactions (erythema multiforme, skin eruptions, epider-  
necrosis, urticaria, serum sickness, pruritus, exfoliative  
atitis, anaphylactoid reactions, periorbital edema, conjunc-  
and scleral injection, photosensitization, arthralgia and  
ic myocarditis); *gastrointestinal reactions* (nausea, emesis,  
minal pains, hepatitis, diarrhea, anorexia, pancreatitis and  
atitis); *CNS reactions* (headache, peripheral neuritis, men-  
epression, convulsions, ataxia, hallucinations, tinnitus, ver-  
and insomnia); *miscellaneous reactions* (drug fever, chills,  
nephrosis with oliguria and anuria, periarteritis nodosa and  
phenomenon). Due to certain chemical similarities with  
goitrogens, diuretics (acetazolamide, thiazides) and oral  
glycemic agents, sulfonamides have caused rare instances  
iter production, diuresis and hypoglycemia as well as thy-

roid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

**Usual adult dosage:** 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

**Usual child's dosage:** 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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Nutley, N.J. 07110





## Letters

Editor's Note: This letter was written to Ernest B. Howard, M.D., Executive Vice President, American Medical Association. Dr. Howard considered it so interesting that he sent copies to the AMA Board of Trustees. It is reprinted by permission from Dr. Howard and Dr. Hampton.

Dear Bert:

The other day I was looking through my old correspondence files in search of a document that George Smathers gave me in 1960, and ran across a brief letter from you in 1964.

I remember well our debates at Legislative Council meetings concerning the wisdom of supporting the proposal for federal financing of health care for the needy aged and the use of insurance carriers (including Blue Shield) as intermediary agents. As I remember, your principal concerns were the possible "capture" of Blue Shield and Blue Cross and of the health care financing system by the federal government. Current events indicate your fears were well founded, although I believe the present federal administration feels they have captured more health care financing than they care to have.

However, the AMA proposal of "Eldercare" which embodied the principles favored in your letter, undoubtedly led to the creation of Part B of Medicare insurance for professional services (separate from Part A Social Security financed institutional services) which, I think, was the most important and far reaching change we were able to effect in that legislative proposal. It also influenced the creation of Medicaid, the relative failure of which, I believe, is due to inadequate and improper state support and failure by the states to use the insurance mechanism for financing medical care.

These events of Act I set the stage for Act II (PSRO implementation) which in turn will determine the course of action in Act III (National Health Insurance).

Current AMA posture in this area was established by the House of Delegates acceptance of

Board of Trustees report Z in 1968. This was the report of the ad hoc Committee on Health Care Financing in which we made three recommendations: 1) Income tax credits as a means of aiding health insurance financing, 2) Peer review for quality evaluation of health care delivery, and 3) Community or regionalized service agencies to aid efficient management of health insurance and effective evaluation by peer review.

The third recommendation for the development of a practical support mechanism necessary for the first two recommendations to operate adequately was apparently filed. My experiences on the HEW Secretary's Task Force emphasized the need to develop this information support mechanism in a manner that would enable truly peer review for qualitative evaluation of medical care. The initial Task Force proposal, to which I vehemently objected, was to create a system to conduct "Peer Review" through government bureaus, which I considered would be detrimental to the quality of medical care; therefore, I set out to develop an alternative information support mechanism as I reported to the Board of Trustees at the Denver meeting in November, 1969.

Meanwhile, the "third party" Medicare carriers have assumed that function to be theirs. This I consider second only to the government bureau system as undesirable, for third party directed review must, of necessity, be cost and not quality-oriented, and would lead to "third party" assumption of traditional medical society responsibilities. Furthermore, their track record for efficiency and economy in handling the information is poor (Committee on Government Operations, House of Representatives, 92nd Congress, Administration of Federal Health Benefits Pro-

grams) and can be appreciably improved by the medical information support system I propose. But, it cannot be accomplished without AMA backing for a contract with the Secretary of HEW to establish a medical information support system in the private sector.

The document, from George Smathers, that I was looking for was a speech intended, but never given, for the Senate in the Spring of 1960 advocating a method of aiding health insurance financing by income tax credits for both the purchaser and the insurance company (you made a copy of it and returned the original). It was supposed to be the result of an abortive "secret" meeting of a committee composed of Senators Kerr, Smathers and Anderson (and advisors) appointed by the Senate majority leader to resolve the health care issue prior to the Democratic National Convention. I subsequently learned that the plan he presented in that speech was devised by Senator Kerr, but was opposed by the insurance industry. Kerr's fall back plan was the Kerr-Mills bill, a predecessor to Medicare.

Here we are, thirteen years later, considering essentially the same proposal which will probably be resolved in this Congress. It will have been an interesting and often frustrating fifteen year play (if limited to three acts). In my opinion, the ending, tragic or providential, will be determined largely by how well physicians conduct truly peer review (including PSRO's). To do it well and maintain a considerable influence on the future course of medical care, we must have our own information support system.

H. PHILLIP HAMPTON, M.D.

► Dr. Hampton, One Davis Boulevard, Tampa 33606.

Dear Editor:

I am glad to respond to some questions and problems posed to me concerning the authority of a Physician's Assistant or an unlicensed physician to prescribe, write and sign prescriptions for medicinal (legend) drugs. Physician's As-

sistants in Florida who are certified by this Board to perform under the supervision of a licensed physician have no statutory authority to prescribe or write and sign prescriptions for drugs which require prescriptions. This constitutes the practice of medicine and should be done only by a licensed physician. The licensed physician must sign the prescription. If a Physician's Assistant has suggested treatment or written a prescription for a patient, this should be checked, approved and signed by the licensed physician who is responsible completely for the prescription. Pharmacists should not fill a prescription which is signed solely by a Physician's Assistant or an unlicensed physician.

Unlicensed physicians who are practicing in an institution, whether a state institution, federal institution or any other area in which unlicensed physicians may perform also including approved internships and residency training programs as well as house officers and house physicians in unapproved programs, have no statutory authority to write and sign prescriptions to be filled outside of that institution. This is likewise the practice of medicine and requires licensure. Any prescription written by an unlicensed physician, if it is to be filled outside, should be checked and countersigned by a licensed physician in the same way as mentioned for the Physician's Assistant above.

Our Board, at our last meeting in January 1973, reaffirmed their ruling that unlicensed physicians may not write prescriptions to be filled in outside pharmacies, but these prescriptions can only be filled within the institution's pharmacy. This question was brought up by the University of Florida College of Medicine and the Board would not agree to allow any unlicensed physician to write prescriptions to be filled outside of the institution. This is the Board's interpretation of the Medical Practice Act, Section 458.13.

It is through the spirit of cooperation between professional boards that we can better perform the functions for which we were created, mainly for the protection of the public and to insure that only properly licensed and qualified professionals furnish health care to the citizens of Florida.

GEORGE S. PALMER, M.D.

► Dr. Palmer, Executive Director, Florida State Board of Medical Examiners, Tallahassee 32301.

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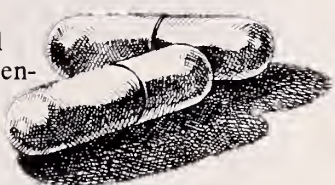




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A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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FAMILY PRACTITIONER to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

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INTERNIST-CARDIOLOGIST, Board certified or board eligible to work along with our present Internist-Cardiologist. Long established group in Hollywood, Florida. Must have Florida license and completed military obligation. Salary open. Write John F. Kerwick, Manager, P. O. Box 2308, Hollywood, Florida 33022.

WANTED-INTERNIST to join coverage group with three other internists. Office space completely furnished now available. Contact R. L. Gillett, M.D., P.A., 1880 Arlington Street, Sarasota, Florida 33579. Phone (813) 958-9589 or 955-3951.

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**UROLOGIST**: Board certified, 36 years old, university trained, F.A.C.S.-F.I.C.S. Five years in private practice, desires to move to a warmer climate. Write C-588, P.O. Box 2411, Jacksonville, Florida 32203.

**BOARD CERTIFIED UROLOGIST** with excellent surgical training. Not licensed in Florida. Would be valuable as assistant in operating room. (House staff status.) Prefer Gulf Coast. Would consider other location. Write C-601, P.O. Box 2411, Jacksonville, Florida 32203.

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# JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.



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JULY 1973

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PROCEEDINGS ISSUE





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



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Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their pre-disposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

# Valium® (diazepam)

To help you manage excessive psychic tension



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JULY COVER—The painting, entitled "The Traveled Path," by Mrs. Robert P. (Bonnie) Vomacka of Belleair Bluffs, won the Editor's Award at the Woman's Auxiliary Seventh Annual Benefit Art Show during the FMA Annual Meeting, May 9-13, 1973 in Miami Beach.

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should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

#### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

#### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

#### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making a substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

#### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution.

I have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

#### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

#### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

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Must vasodilators  
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other diseases  
come into  
conflict?



not if the vasodilator is

**VASODILAN<sup>®</sup>**  
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the compatible vasodilator...  
no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator. Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease. In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: *Geriatrics* 25:134-148 (May) 1970.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

**Possibly Effective:**

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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## President's Page



### PSRO - Washington - Watergate

Past trips to the nation's capitol on behalf of organized medicine have been exhilarating experiences—but, this last one was different. To prevent bugging, pictures have been removed leaving only empty hooks adorning the stark walls of congressional conference rooms and imparting graphic reminders that Watergate dominates activity and thought in Washington today.

Along with representatives of 36 other state medical associations, we visited congressional delegations to discuss PSRO and the advantages of a state umbrella system. We found, however, that Congressmen, like everyone in Washington, were preoccupied with Watergate. PSRO, National Health Insurance, abortion, Phase III, and the economic crisis just were not relatively important.

To one who has always enjoyed and been fascinated by the political action phase of organized medicine, the changed atmosphere in Washington was shocking. I was reminded of a visit to Moscow, where the uninterrupted queue of visitors at Lenin's Tomb results in a perpetual funeral, thus adding depression to an already oppressed city. The queue in Washington forms early outside the Senate Watergate hearings; it seems to add emphasis to the apparent halt in governmental processes, thus, the accustomed feeling of pride from watching democracy in action is replaced by frustration and similar depression.

Our congressional delegation was courteous and apparently attentive as we argued convincingly against dividing states into smaller regions reporting directly to HEW. However, we wondered if our seeming success was, instead, a case of shortened attention spans, preoccupied acquiescence, or just being tuned out. These men are so emotionally, psychologically, and physically involved in the Watergate issues that the machinery of government has almost ceased to function.

A dark cloud, or pall, hangs low over our capitol. Yet, since PSRO could paralyze our profession as has Watergate the government, there might be a tinge of silver in the lining.

Accountability seems to be the new game as citizens question the very fabric of our nation. No longer is the health care delivery system the only whipping boy as Americans scrutinize education, the courts, churches, and even challenge the integrity of our President. HEW usurping power through flagrant regulations, contrary to the intent of Congress, disturbs, and rightfully so, our lawmakers. Exploitation of patients by a few physicians portrays for the whole of medicine an ugly doctor image. Today our society demands logical reasoning and explanations from all institutions, government agencies and professions.

The standstill created by Watergate allows a necessary "time out" for reconnoitering of our tattered principles and ideals. Maybe we have been afforded a reprieve! Perhaps now we too can insist on utilizing our expertise in PSRO! Maybe even Congress now prefers laissez-faire in lieu of more government spending and services. Maybe the pall over Washington today will, in the final analysis, be a blessing in disguise.

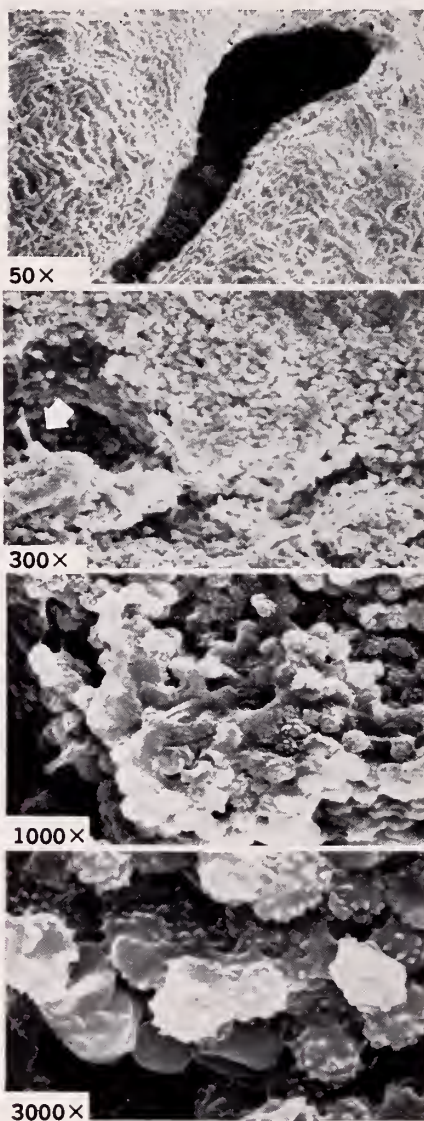
Let's hope so.



# Progress in Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50X), a fibrin strand (300X), and a whitish exudate composed of polymorphonuclear leukocytes (1000X and 3000X). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



## A note on the photography:

These photographs were made by the scanning electron microscope, which, like the transmission electron microscope, operates on the basic principle of exposure of tissue to a beam of electrons in a vacuum. With the SEM, electrons bombard the surface of tissue which has been given a fine coating of gold. The electrons reflect off the tissue onto a television screen, and the resulting photograph shows a three-dimensional effect. The tissue sections need not be ultrathin, so there is a minimum of handling and distortion.

Just as much an instrument of progress and just as helpful in its way has been Gantrisin (sulfisoxazole) Roche, developed and introduced a generation ago. However, there's been no generation gap over its continuing usefulness. In fact, Gantrisin, with so many years of clinical experience behind it, is still one of the most valuable drugs we have for the treatment of non-obstructed cystitis, pyelitis or pyelonephritis due to susceptible organisms such as *E. coli*. Specifically, Gantrisin provides your patients with certain important therapeutic advantages:

**References:** 1. Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther.*, 12:525, 1971. 2. Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc.*, 44:318, 1969. 3. Hibbard, L. T., in Bulger, M. J., et al.: *Patient Care*, 1:(3) 47, 1967. 4. Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol.*, 102:249, 1969. 5. House, T. E., et al.: *Obstet. Gynecol.*, 34:670, 1969. 6. Lampe, W. T.: *J. Am. Geriatr. Soc.*, 16:798, 1968. 7. Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res.*, 13:286, 1971. 8. Normand, I. C. S.: *Practitioner*, 204:91, 1970. 9. Pryles, C. V.: *Med. Clin. North Am.*, 54:1077, 1970. 10. Seneca, H.; Peer, P., and Warren, B.: *J. Urol.*, 99:337, 1968. 11. Trafton, H. M., and Lind, H. E.: *J. Urol.*, 101:392, 1969. 12. Cohen, M.: *Pediatrics*, 50:271, 1972.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

**IMPORTANT NOTE:** *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml;

measure levels as variations may occur. **Contraindications:** Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

**Warnings:** Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Check and urinalysis with careful microscopic



# acute cystitis:

## Treatment

**high urinary levels** As a urinary anti-bacterial, Gantrisin (sulfisoxazole) offers your patients important advantages. Therapeutic urinary and plasma concentrations are usually reached in from 2 to 3 hours and can be maintained on the recommended 8 Gm/day dosage schedule that's convenient for almost all patients.

**generally good tolerance** Gantrisin causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Hence, Gantrisin may usually be given even for extended periods in treating chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms. (See Important Note in summary of prod-



uct information.) Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

**high solubility** Gantrisin (sulfisoxazole) Roche is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in

60 minutes; therapeutic levels are usually reached in from 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

**economy** Average cost of therapy is still only about 6½¢ per tablet.

**total therapy: 14 days** Recent evidence in the medical literature suggests that therapy in acute non-obstructed urinary tract infections should be continued for 10 to 14 days even if patients become asymptomatic in 2 or 3 days, as they often do.<sup>1-11</sup> However, one investigator, evaluating a 5-year study of sulfisoxazole used to treat urinary tract infection in 368 girls, found no advantage in continuing therapy more than two weeks for a first infection.<sup>12</sup>

**For acute, chronic or recurrent nonobstructed cystitis, pyelitis, or pyelonephritis due to susceptible organisms...**

begin with  
**Gantrisin<sup>®</sup>**  
**sulfisoxazole/Roche<sup>®</sup>**

**Usual adult dosage:** 4 to 8 tablets *stat*  
2 to 4 tablets *q.i.d.*

ation should be performed fre-

**Reactions:** Use cautiously in patients with impaired renal or hepatic function, allergy or bronchial asthma. Nausea, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalline stone formation.

**Reactions:** Blood dyscrasias: leukopenia, aplastic anemia, thrombocytopenia, hemolytic anemia, purpura, hypoprothrombinemia and hemoglobinemia; **Allergic reactions:** skin rash, erythema multiforme (Stevens-Johnson

syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; **Gastrointestinal reactions:** Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; **C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; **Miscellaneous reactions:** Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L.E. phenomenon have occurred. Due

to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Supplied:** Tablets containing 0.5 Gm sulfisoxazole.



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Symptomatic relief should not delay definitive diagnosis or treatment.

#### Dosage and Administration

Anusol-HC: One suppository in the morning and one at bedtime for 3 to 6 days or until the inflammation subsides.

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## Medical News

### Florida Physicians Participate in AMA Meeting

At the annual AMA meeting last month, the following FMA physicians served as delegates: Rufus K. Broadaway, Miami; Richard G. Connar, Tampa; Samuel M. Day, Jacksonville; Burns A. Dobbins, Ft. Lauderdale; Francis T. Holland, Tallahassee; Robert E. Zellner, Orlando. Alternates are: Jack Q. Cleveland, Coral Gables; Francis C. Coleman, Tampa; James T. Cook, Marianna; Charles K. Donegan, St. Petersburg; Eugene G. Peek Jr., Ocala and Thomas B. Thames, Orlando.

Representing the specialty of allergy at the House of Delegates meeting was Robert J. Brennan, Ft. Lauderdale; representing Psychiatry, was James N. Sussex, Miami, and representing Urology, David W. Goddard, Daytona Beach.

Serving on the Reference Committee for Amendments to the Constitution and By-Laws was Francis T. Coleman who also is the new chairman of the AMA Council on Health Manpower.

Jere W. Annis of Lakeland, a member of the Board of Trustees, also serves on the Long Range Planning and Development Council. Granville W. Larimore of Tampa is a member of the Council on Environmental, Occupational and Public Health.

Roger T. Sherman of Tampa appeared on a postgraduate course entitled Life Saving Measures for the Critically Injured, discussing "Assessment of the Critically Injured." On the postgraduate course entitled Infectious Diseases, Leighton E. Cluff of Gainesville discussed "Antimicrobics, Nosocomial, and Iatrogenic Infections." During the General Session, Meyer B. Marks of Miami Beach presented a paper on "Unusual Signs of Respiratory Tract Allergy."

"Central Corneal Edema," is the topic of a paper by Herbert E. Kaufman of Gainesville who, also appeared on a postgraduate course entitled Drugs of the Decade; J. Donald M. Gass of Miami discussed "Nicotine Maculopathy," and J. Philip Ritchey of Miami discussed "Subconjunctival Nodules Following Amphotericin Injection for Mycotic Keratitis."

Appearing on a special course entitled "Cardiopulmonary Resuscitation," was James R. Jude and Eugene L. Nagel of Miami.

Ross Davis of Miami was a participant of the Symposium on Spasticity and discussing "Spasticity and the Neurosurgeon." Alan Rapperport of Miami was a participant on a panel in the Section of Plastic and Reconstructive Surgery, the moderator being Ira M. Dushoff of Jacksonville.

A movie entitled, "First . . . A Child," was shown by Arlan L. Rosenbloom of Gainesville.

T. Norley of Palm Beach manned a special exhibit on fractures; B. J. Wilder of Gainesville presented a paper on "Management of the Geriatric Patient Suffering from Symptoms of Senility." Francisco Civantos, Carlos J. Dominguez, Arkadi M. Rywlin and John DiBella, all from the Mt. Sinai Medical Center of Greater Miami, Miami Beach, presented a paper on "Protein Immunoelectrophoresis." Leon Sheplan of Miami is co-author of a paper entitled "Clinical Evaluation of Dantrolene Sodium, A Unique Muscle Relaxant."

### University of Miami Receives Three Year Grant

The John A. Hartford Foundation, Inc. has renewed a three year grant in the amount of \$187,153 to the University of Miami School of Medicine for continuing basic research into the nature of the myelin membrane, which is subject to destruction in such diverse diseases of the nervous system as multiple sclerosis, phenylketonuria and Tay Sachs' disease.

The late Dr. Seymour Joffe, associate professor in the School's Department of Neurology, was the principal investigator in the project which bears the title, "The Structure and Organization of Myelin in Relation to Dysfunction in the Central Nervous System." Dr. Peritz Scheinberg, Professor and Chairman, Department of Neurology, is administering the project on an interim basis.



### Three Versus Four

DONN L. SMITH, M.D.

Medical educators and interested members of the practicing profession are now involved in some lively and productive discussions which concern the movement in a number of medical colleges to the three-year curriculum.

Prior to making the decision to adopt the three-year program, the college generally undertakes a careful study of the pros and cons. Included is the acquisition of data from institutions who are currently operating in the three-year mode. Considerable debate then takes place within the medical faculty and a number of important considerations are weighed in the process of debate concerning three vs four.

The typical concerns relate to: (1) Will the medical student be capable of the appropriate maturation within the reduced time frame? (2) Is it possible to provide an adequate academic background in a three-year period? (3) Will the student be able to withstand the increased pressures which must inevitably accompany academic acceleration? (4) Will the faculty be able to adjust to the increased productivity in teaching that is required, and will the needed sustained academic effort be possible over a period of time? (5) Most importantly, perhaps, is the question of possible deprivation of the student of some intellectual enrichment offered by the loss of about nine months of free time normally available in the four-year mode for exposure to research, preceptorships or advanced study.

The decision to adopt an accelerated program or to retain the traditional four-year posture is usually made in the context of the answers which evolve to the five questions listed above. The entire question arises within a frame of reference of pressures for reduced time expenditure for the production of the finished product. An important consideration arises in terms of expense to the

student related to an additional year of continued expenditures versus a year of income generated as a member of the house staff. Attractive to the student is the fact that by virtue of the accelerated program he or she gains one additional year of full practice during the course of his or her career. The income accrued during any given year of practice will, of course, help defray the cost of the educational process.

Against this general background, then, each college considers, debates and finally arrives at the decision to accelerate or not to accelerate. The entire process is truly an exercise in academic freedom and the extraneous pressures and semi-political nature of the problem should not become major determinants in the adoption of a given policy by the medical faculty. Nor should educators allow the insertion of the domino effect wherein a move towards acceleration by one college leads to a similar decision by others without full and mature consideration given to the above five questions by each faculty with full freedom to arrive at a decision based on the best interests of each school.

In Florida, two of the three Colleges of Medicine have adopted the accelerated curriculum, the third has not. It would be with great regret that we at the University of South Florida would find our move towards acceleration to be employed as an additional bit of pressure to be applied to any other college to follow suit. It is healthy and desirable that each institution make its own decision based on the best judgment of its own faculty.

And last, but by no means least, it seems to me that whatever the rate of the program to be adopted, each student is entitled to an opportunity to obtain an appropriate adjustment of his rate of progress. The medical student should be allowed, even encouraged to move more quickly towards the M.D. if he is judged to be capable of doing so, and by the same token, the student must be granted the privilege of a slower pace

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

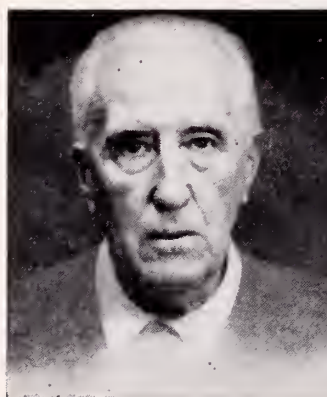
within an accelerated program if cogent reasons for it are demonstrated. This kind of flexibility represents the academic maturity which should characterize a competent and progressive program of medical education.

It is my hope that as our undergraduate programs in medical education develop this necessary flexibility, the programs in postgraduate education leading to specialty certification may also begin to become more flexible.

In the meantime, we are engaged in a most interesting experiment in medical education which

is relevant to a reasonable and hopefully acceptable compression of the traditional time frame for undergraduate medical education. The products of acceleration will either justify the concept, or will provide a clear indication for a return to a more leisurely pace. Those of you in practice will, in due course, sit in judgment on our graduates, and will properly apply some meaningful input to the process of future academic decision as it applies to three vs four.

► Dr. Smith, University of South Florida, Tampa 33620.



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**CONTRAINDICATIONS:** There are no known contraindications to Menic.



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or inserter...of particular value for the pregnant  
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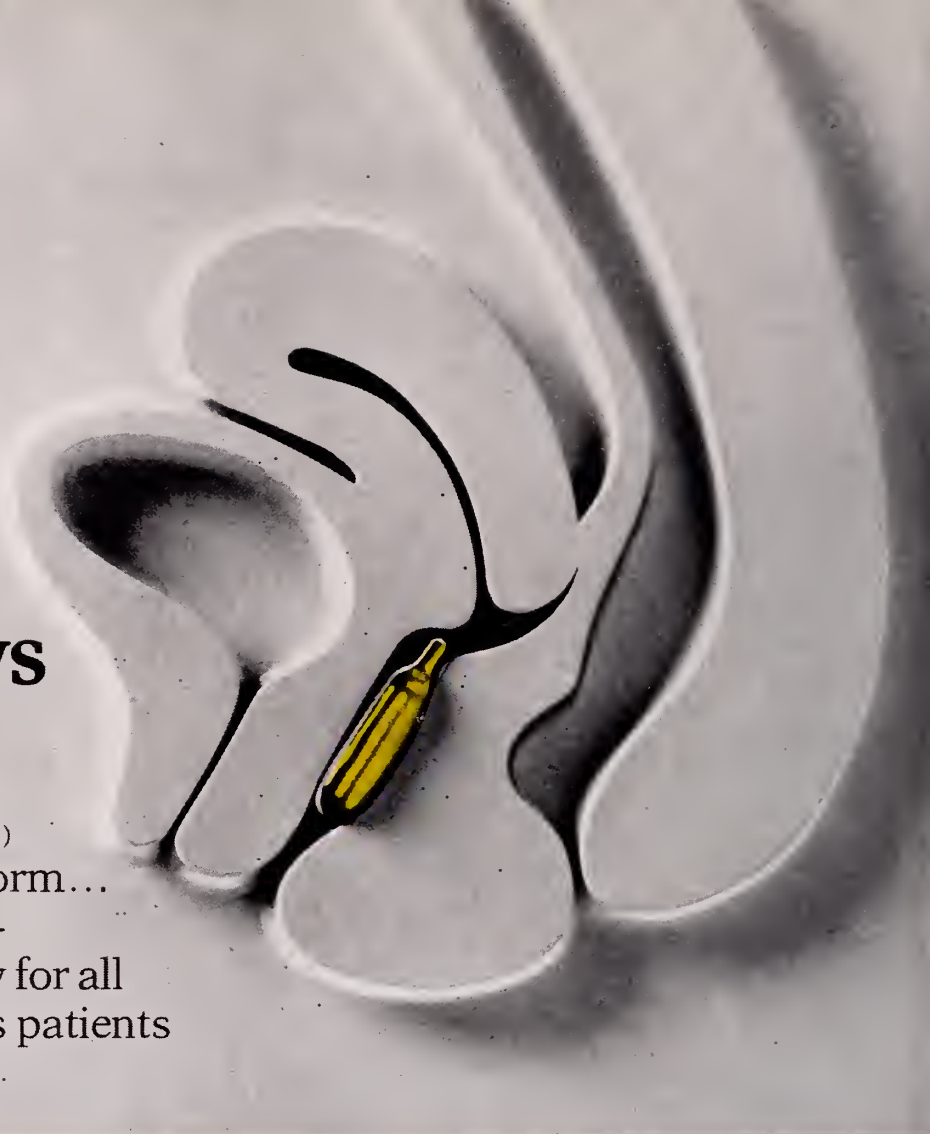
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patients.<sup>1,4,6</sup> In recent studies on CANDEPTIN  
VAGELETTES Vaginal Capsules, involving both gravid  
and non-gravid patients, a 100% culture-confirmed  
cure rate was achieved with a single 14-day  
course of therapy.<sup>2,3</sup>

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**Description:** CANDEPTIN (candidin) Vaginal Ointment contains a dispersion of candidin powder equivalent to 0.6 mg. per gm. or 0.06% Candidin activity in U.S.P. petrolatum. 3 mg. of Candidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candidin powder equivalent to 3 mg. (0.3%) Candidin activity dispersed in starch, lactose and magnesium stearate. CANDEPTIN VAGELETES Vaginal Capsules contain 3 mg. of Candidin activity dispersed in 5 gm. U.S.P. petrolatum.

**Action:** CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETES Vaginal Capsules possess anti-monomial activity.

**Indications:** Vaginitis due to *Candida albicans* and other *Candida* species.

**Contraindications:** Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

**Caution:** During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

**Adverse Reaction:** Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETES Vaginal Capsules have been extremely rare.

**Dosage:** One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

**Available Dosage Forms:** CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN VAGELETES Vaginal Capsules are packaged in boxes of 14 (14-day regimen requires 2 boxes.)

Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

**References:** 1. Olsen, J.R.: *Journal-Lancet* 85:287 (July) 1965. 2. Giorlando, S.W.: *Ob Gyn Dig.* 13:32 (Sept.) 1971. 3. Decker, A.: *Case Reports on File, Medical Department, Julius Schmid.* 4. Giorlando, S.W., Torres, J.F., and Muscillo, G.: *Am. J. Obst. & Gynec.* 90:370 (Oct. 1) 1964. 5. Lechevalier, H.: *Antibiotics Annual 1959-1960.* New York, Antibiotics Inc., 1960, pp. 614-618. 6. Friedel, H.J.: *Maryland M.J.* 15:36 (Feb.) 1966.

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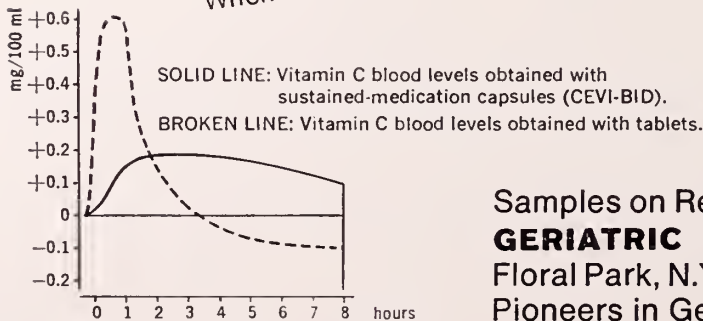
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<sup>1</sup> Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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# FEEDBACK -from Pearl Street

## Recommended Schedule for Compulsory Immunizations

Certain immunizations are required for school entrance in Florida. This schedule will accomplish the goal of completing compulsory immunizations as early as is reasonably possible. Additional immunizations, currently held desirable but not required such as mumps, may be given supplementarily.

AGE AT FIRST VISIT	FIRST VISIT	SECOND VISIT (4 weeks later)	THIRD VISIT (6 weeks later)	FOURTH VISIT (age 12 months)	BOOSTER VISIT (12 months after third visit)
Under 2 months	No Immunizations				
2-12 months	DPT OPV	DPT	DPT OPV	Measles <sup>1</sup> Rubella	DPT OPV
1-6 years <sup>2</sup>	DPT Measles <sup>1</sup> Rubella	DPT OPV	DPT OPV		DPT OPV
7-11 years <sup>3</sup>	Td Measles <sup>1</sup> Rubella	Td OPV	OPV		Td OPV
12-17 years	Td OPV	Td	OPV		Td OPV
18 years+	Td	Td			Td

DPT—Diphtheria-Pertussis-Tetanus  
OPV—Oral Poliomyelitis Vaccine  
Td —Tetanus-Diphtheria, Adult Type

<sup>1</sup>If combined measles/rubella a vaccine is not available individual vaccines should be injected at different sites.

<sup>2</sup>The 1 through 6 years age group recommendations can be used for all children in preschool day care centers, kindergarten and first grade.

<sup>3</sup>The 7 through 11 years age group recommendations can be used for all children through the fourth grade. Rubella vaccine should be omitted after fifth grade and/or 11th birthday, measles after six grade and/or 12th birthday. Except during pregnancy, measles vaccine may be given after 12th birthday if there is no history of measles.

## Mosquito Control

Mosquitoes are directly affected by the amount of water generated by certain weather conditions. When there are alterations such as heavy rains, a new fringe breeding area is created. Virus activity is optimal in this situation. Since normal mosquito populations offer sufficient disease risk to cause concern, current conditions demand close surveillance, particularly in the northern portion of the state. The first sign of arboviral activity determined by the surveillance systems, vector trapping, sentinel animals and human cases, causes mosquito control to go into operation to knock down the mosquito population. The weakest link in this chain is case identification. When a case, even a suspect case, of arthropod-borne disease is reported, public health officials set the control mechanism in motion and, at the same time, aid the clinician in the collection and processing of specimens to determine exact etiology

## Infant Death Rate

Florida has one of the lowest infant death rates among the southern states but the rate is above that for the United States. The 1971 rate per 1,000 live births for Florida was 20.7, for the United States 19.2. When the rates are compared on a race specific basis, Florida's rate is less than one death per 1,000 live births higher than the United States for each category. In 1971 the white infant death rate per 1,000 live births for Florida was 16.8, for the United States 17.1; Florida nonwhite 30.2, United States nonwhite 30.9.

Florida live births have declined only about 6.6% compared to a national decline of 8.5%. From 1971 to 1972 these states showed greater declines: Georgia 11.5%, Alabama 6.8%, Mississippi 6.1%, South Carolina 7.8%, and North Carolina 6.8%.

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## PROCEEDINGS

Ninety-Ninth Annual Meeting—Florida Medical Association, Inc.

Miami Beach, May 9-13, 1973

### President's Address

WILLIAM J. DEAN, M.D.

Fellow Members of the Florida Medical Association, Ladies and Gentlemen—and Visitors—

As I appear before you today, the one chance to speak to you as President of the Florida Medical Association, I had wondered just what subject would be most appropriate. I have been extremely proud of your Board of Governors and your many hard-working Council and Committee chairmen and members. Each of these men has put in many hours on behalf of Florida medicine, and the input of their talents has been such that I can say no more than they have done a great job. I wish it were possible to thank each man individually for his efforts. The activities of your Association this past year, are well covered in your Delegate's Handbook under the report of Board of Governors. Anyone who reads this entire section, as well as the other portions of the Handbook, will know that we have been busy meeting the day by day challenges, as well as trying to anticipate future problems and prepare for them before they actually arrive on the scene.

Many people have been critical of the medical profession, maintaining that we haven't presented a new approach in giving positive ideas for the future of medical care delivery, but have rather

criticized new proposals as brought forth by non-medical groups. I feel that most of this criticism is unjust in that those of us who are spending long and full days in practice simply do not have the time or the knowhow to plan future medical



President William J. Dean, M.D., St. Petersburg, delivers his Presidential Address.



care delivery systems. Organized medicine has tried very hard over the last few years to make positive imaginative approaches; the AMA has come forward with its Medi-Credit Program of Medical Care, which has many sponsors in the United States Congress.

There is so much frustration in the world today that I am afraid some of this has rubbed off on all of us. The medical profession, we doctors, seem to be extremely upset and tense because we realize that third parties are nipping at our heels and trying to change the form of practice that we have all chosen as a life's work. Most of us do realize that there must be changes. Although it would be nice to be able to turn back the clock, this simply is not practical or possible. We must have changes in our method of delivery of medical care, but I think we are all hoping that the changes will be built on the present working system, and not turn out to be an entirely new program with destruction of our present system and total replacement with the new.

The point that I wish to try to make today is that the most important thing for all of us to realize is that we must have *UNITY*. This unity must be in our profession. If we can't find some way to join together and work for a common goal, I feel certain that the bureaucrats will take over the practice of medicine because we have not been able to provide and keep up. To me, there is no doubt but that the strongest arm that

we can possibly present to the American public is through our current organizational structure consisting of our County Medical Societies, State Medical Associations, and nationally, the American Medical Association. In spite of what you may believe or have heard, this is a grass roots program. Of all the organizations existing today, this one, by far, has the best knowhow and ability to accomplish the goals we are seeking.

I have been personally perturbed by the number of splinter groups that seem to be springing up with their main theme being criticism of the AMA and their main goals simply turning back the clock and preaching nonparticipation. Our one chance to succeed is to realize that we must put all our efforts into the one group that can speak best for us.

One of the reasons that we have not been able to all get together in a united group is that we have heard so many divergent ideas and opinions that we frankly didn't know which ones were right. We must learn to listen and sift the truth from the mere rumors. If we have some understanding of where we have gone astray, we will be better able to get back on the right path.

I want you to see a film with me and listen. We must not let them cut our tree limb by limb. Just listen with me!

(A film entitled "Three Days in February," produced by the AMA was shown here).

---

## Interesting Statistics from the Florida State Board of Medical Examiners—May 2, 1973

There are 18,000 M.D.s licensed to practice medicine in Florida.  
10,240 have Florida addresses  
8,409 are FMA members.

# General Session

The General Session of the 99th Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 11, 1973, in the Bal Masque/Medallion Room of the Americana Hotel, Bal Harbour, Florida, by President William J. Dean, M.D.

Dr. Dean announced the winners of the awards for scientific exhibits.

## 1973 Scientific Exhibit Awards

*First Place:* Siby Pada Saha, M.D.; L. Alan Smith, M.D. and Sam E. Stephenson Jr., M.D., Jacksonville: *"Sigmoid Volvulus"*

*Second Place:* Melvin Levinson, M.D. and Ian Reiss, M.D., South Miami: *"Colonoscopy: Extending the Surgical Frontier"*

*Third Place:* Dale K. Lindberg, M.D. and Melvin M. Stone, M.D., Hollywood: *"A Private Community Methadone Maintenance Unit"*

*Honorable Mention:* Thomas O. Gentsch, M.D.; Parry B. Larsen, M.D.; Ernest A. Traad, M.D.; Arthur J. Gosselin, M.D., and Paul S. Swaye, M.D., Miami: *"Coronary Reconstruction with Internal Mammary Artery Bypass Grafts"*

William Schumer, M.D.; Peter Erve, Ph.D.; Sheldon O. Burman, M.D.; Lloyd M. Nyhus, M.D., and A. Gerson Greenburg, M.D., Chicago, Illinois: *"Endotoxin Shock"*

Charles E. Virgin, M.D. and Clifford C. Raisbeck Jr., M.D., San Francisco, California; John J. Fahey, M.D. and Donald J. Maylahn, M.D., Chicago, Illinois: *"Regenerative Management of Finger Tip Amputations"*

Bernard M. Norcross, M.D. and David L. Berens, M.D., Buffalo, N. Y.: *"Joint Diseases: Clinical and X-ray Findings"*

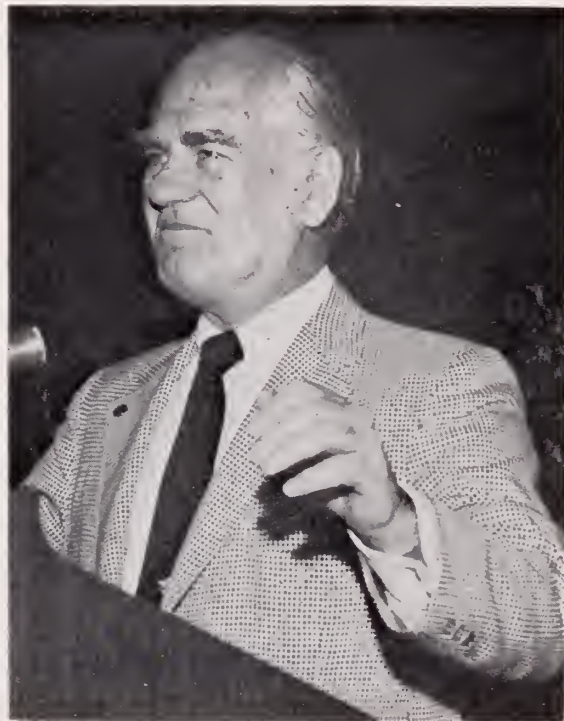
Dr. Dean announced that former Senator Verle Pope of St. Augustine was selected to receive the Florida Medical Association's first Distinguished Layman Award. Senator Pope was unable to be present to receive the award, however, due to illness. Arrangements have been made for Dr. Von Thron, Dr. Walker, and Dr. DeVito to present this award to Senator Pope in St. Augustine at a later date.

Mrs. James J. DeVito, Mrs. Donald R. Hagel, Mrs. Ernest R. Casey, and Mrs. C. Herbert Gilliland presented a check in the amount of \$6,732.85 to the President of the Florida Medical Foundation, Dr. Dean, representing funds raised for the Foundation by the Woman's Auxiliary. Dr. Dean gratefully acknowledged the check and commended the ladies on the outstanding work which they have done over the past year.

Dr. Dean recognized and greeted the Student AMA Representatives, Mrs. Patti Berry, University of South Florida; Mr. Richard Bowdle and Mr. Robert Wetzell, University of Florida; and Mrs. Jean Threasher, University of Miami.

Dr. Dean also welcomed Dr. W. J. Lewis, President, American Medical Political Action Committee.

Dr. Dean introduced his guest Speaker, Russell B. Roth, M.D., of Erie, Pennsylvania, President-Elect, American Medical Association, who presented the annual Baldwin Lecture.



Russell B. Roth, M.D., Erie, Pennsylvania, President-Elect of AMA, presenting the Baldwin Lecture.

Dr Roth recalled that physicians of yesteryear—and particularly in the day of Dr. Abel Baldwin, for whom the annual lecture is named—kept divorced from political issues.

"We all deplore the necessity of being involved in pragmatic politics," the AMA official said, but because so many medical issues are being hashed out in the state legislatures and the Congress, the doctors of America have no choice.

He stated that there are at least three health-related decision areas which "have not been solidified." First among them is the "priority to assign to health services."

"It is curious," he said, "that health care did not surface as a major issue during the 1972 presidential campaign. We have not found a commanding voice that health is a No. 1 priority," he added.

Another unresolved issue, according to Dr. Roth, is whether emphasis should be on the

quality, quantity or cost of medical care.

And lastly, it must be determined "whether we are under a compulsion to rigidly systematize medical care."

Multiple frustrations confronting the profession today, including Phase III controls, Medicare, Medicaid, HMOs, national health insurance, and television documentaries on health, have tended to spawn new organizations of doctors with limited purposes.

Despite this, "the AMA has acted responsibly and has acted in an increasingly effective fashion for practicing doctors," Dr. Roth observed.

He said the AMA has room for doctors of all persuasions, radicals and conservatives included.

"AMA has been identified with defense of the status quo," he said. "Actually," he continued, "AMA is a progressive institution."

The President adjourned the General Session at 11:45 a.m.

## First House of Delegates

The First House of Delegates convened at 4:30 p.m. on Wednesday, May 9, 1973, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

The invocation was given by Dr. William C. Roberts, Past President, of Panama City.

The Speaker announced the membership of the Credentials Committee: Drs. Donald G. Nikolaus, Chairman, Edward W. St. Mary, and Yank D. Coble Jr.

The Chairman of the Credentials Committee, Dr. Nikolaus, reported a quorum of 154 delegates present out of a possible 204, representing a majority of the delegates and a majority of the component medical societies, and moved that the delegates be seated. The motion carried.

### Delegates

ALACHUA—Allen Y. DeLaney, David M. Drylie, Charles H. Gilliland, George W. Little, George H. Miller Jr., Gerold L. Schiebler.

BAY—James Phillips, W. C. Roberts.

BREVARD—John T. Blackburn, Michael J. Foley, Edwin E. Hadden Jr., T. John Kaminski, Robert C. Seelman.

BROWARD—Miles J. Bielek, Andre S. Capi, Ray E. Murphy Jr., Frank B. Ott (Absent—Russell B. Carson, Milton P. Caster, Richard S. Doyle, Leonard A. Erdman, Joseph E. Gelety, F. Gary Gieseke, Paul E. Gutman, David C. Lane, John R. Mahoney, Henry D. Perry Jr., James B. Perry, W. Dotson Wells, John I. Williams).

CHARLOTTE—Melvyn J. Katzen.

CLAY—Laurin G. Smith III.

COLLIER—Foster L. Bullard Jr., Hoke H. Shirley Jr.

COLUMBIA—John T. Wilson.

DADE—Jerome Benson, Rufus K. Broadaway, John O. Brown, Manuel L. Carbonell, Jack Q. Cleveland, A. J. Fernandez Conde, Vincent P. Corso, Dewitt C. Daughtry, O. William Davenport, Joseph H. Davis, Richard C. Dever, J. Lee Dockery, Miguel Figueroa Jr., Richard M. Fleming, M. Eugene Flipse, Marshall F. Hall, Henry C. Hardin, Joseph Harris, Walter C.



Jones III, Maurice H. Laszlo, Carlos G. Llanes, Rose E. P. London, Seymour B. London, Ronald J. Mann, Ildefonso R. Mas, Bruce E. Miller, Charles A. Monnin, Sheldon D. Munach, Jorge R. Pena, Julian A. Rickles, Ronald H. Scherr, Janice K. Sherwood, Everett Shocket, Edward W. St. Mary, William M. Straight, Charles F. Tate Jr., Maynard F. Taylor, Arthur W. Wood Jr., Scheffel H. Wright, Sheldon Zane (Absent—Richard C. Clay, Robert F. Dickey, Pedro J. Greer, Banning G. Lary, Milton E. Lesser, Aaron Medow, Walter W. Sackett Jr., Daniel L. Seckinger II, Ruth A. R. Simons, Robert E. Willner).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Warren M. Barrett, James L. Borland Jr., Yank D. Coble Jr., Clyde M. Collins, Stephen P. Gylard, Millard F. Jones, Thad M. Moseley, Sanford A. Mullen, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander (Absent—Emmet F. Ferguson Jr., Leonard E. Masters, Charles B. McIntosh, Faris S. Monsour Jr.).

ESCAMBIA—Charles J. Kahn, Theodore J. Marshall, Philip B. Phillips, F. Norman Vickers, William M. C. Wilhoit.

FRANKLIN-GULF—(Absent—Joseph P. Hendrix).

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Irving M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Thomas E. McKell, W. Mahon Myers, Curtis G. Rorebeck, William W. Trice, Harold L. Williamson (Absent—Richard S. Hodes).

INDIAN RIVER—(Absent—J. C. Robertson, Daniel Thornton).

LAKE—Fred C. Andrews, Thomas D. Weaver.

LEE—Larry P. Garrett, F. Lee Howington (Absent—J. Stewart Hagen III).

LEON-WAKULLA-JEFFERSON—Edward G. Haskell Jr., Nelson H. Kraeft, Robert N. Webster.

MADISON—(Absent—Johnson Bibb).

MANATEE—John D. Lehman, Roger A. Meyer, Millard P. Quillian.

MARION—Henry L. Harrell, C. Brooks Henderson.

MONROE—Ronald H. Chase.

NASSAU—Marshall E. Groover.

OKALOOSA—William W. Thompson.

ORANGE—Norman F. Coulter, Eugene N. Forrester, Clifford L. Garrard Jr., Joseph G. Matthews, Franklin B. McKechnie, James F. Richards Jr., Edward W. Stoner, Thomas B. Thames (Absent—Edward L. Farrar, Paul C. Harding, Franklin G. Norris, Ronald M. Wilson).

OSCEOLA—George A. Gant.

PALM BEACH—Carl E. Andrews, Vernon B. Astler, Curtis W. Cannon, Jerry F. Cox, J. Russell Forlaw, Bernard Kimmel, Richard B. Moore, Dick L. Van Eldik (Absent—Willard F. Ande, James R. Brandon, George L. Ford Jr.).

PANHANDLE—(Absent—William F. Brunner).

PASCO-HERNANDO-CITRUS—James P. Gills Jr., Randall W. Jenkins.

PINELLAS—Charles K. Donegan, James C. Fleming, Daniel S. Helman, Roger A. Laughlin, Jack A. MacCris, William G. Mason, Walter S. McKeithen Jr., James H. Miller Jr., Donald G. Nikolaus, David T. Overbey, Thomas M. Quehl, Rowland E. Wood (Absent—Joseph A. Ezzo).

POLK—J. Gerard Converse, Howard M. DuBose, John W. Glotfelty, Willard E. Manry, Frank Zeller Jr. (Absent—Marvin G. Burdette).

PUTNAM—Roy E. Campbell.

ST. JOHNS—W. W. O'Connell.

ST. LUCIE-OKEECHOBEE-MARTIN—Howard C. McDermid, John F. Powers.

SANTA ROSA—(Absent—Claude J. Barnes).

SARASOTA—John N. Carlson, F. H. Pfeifferberger, Karl R. Rolls, Robert E. Windom (Absent—F. Edwards Rushton).

SEMINOLE—(Absent—John T. Johnson).

SUWANNEE-HAMILTON-LAFAYETTE—(Absent—Hugo F. Sotolongo).

TAYLOR—John A. Dyal.

VOLUSIA—Octavius B. Bonner Jr., William E. Carter (Absent—Thomas W. Ayres, Charles A. Stump).

WALTON—Howard F. Currie.

SPEAKER OF THE HOUSE—Franklin J. Evans.

VICE SPEAKER OF THE HOUSE—Louis C. Murray.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

### Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at *each meeting* of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Whenever possible, it is requested that resolutions and supplemental reports be forwarded



Very intent on matters at hand at the House of Delegates: (foreground left to right) are Leo M. Wachtel, M.D., Jacksonville; W. Dean Steward, M.D., Orlando; Walter C. Jones, M.D., Miami; Jere Annis, M.D., Lakeland; Robert E. Zellner, M.D., Orlando and Eugene G. Peek Jr., M.D., Ocala.

to the Association's executive office by April 25 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

A resolution before the Reference Committee must have a sponsor present before the Reference Committee. All resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be duplicated and available at the Reference Committee meetings when they convene. Only the 'resolved' portion of resolutions will be adopted as policy. Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House.

We also plan to have all Reference Committee reports duplicated and available to the delegates at the Registration Desk on the morning of the day the Second House of Delegates meets in the afternoon. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, as well as those which will be in the Delegates' Packets and the reports of the Reference Committees, have been color coded for easy reference. This color code is as follows:

- Reference Committee No. I —Green
- Reference Committee No. II —Buff
- Reference Committee No. III—Blue
- Reference Committee No. IV—Pink
- Reference Committee No. V —Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented to the House, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Franklin J. Evans, Speaker  
House of Delegates  
Louis C. Murray, Vice Speaker  
House of Delegates

The following correction was made in the Proceedings of the 1972 House of Delegates, as published in the July 1972 issue of the Journal of the Florida Medical Association: In the Second House of Delegates, Recommendation 1 of the Council on Allied Professions and Vocations, Page 42, the word "concerned" should be "concerted."

A motion carried to approve the minutes of the 1972 House of Delegates as corrected.

The Speaker introduced the officers of the Association: Drs. William J. Dean, President;

Joseph C. Von Thron, President-Elect; Floyd K. Hurt, Immediate Past President; John C. Fletcher, Vice President; James W. Walker, Secretary and Treasurer; Louis C. Murray, Vice Speaker of the House; and Mr. W. Harold Parham, Executive Vice President.

The Speaker then instructed the House.

### Remarks of the Speaker

President Dean, officers of the Association, Delegates and Alternate Delegates, it is my pleasure to welcome you to this, the 99th annual meeting of the Florida Medical Association.

I am particularly pleased and happy to be back in this familiar role of Speaker of the House of Delegates. This is indeed an honor tempered only by certain duties and responsibilities. It is the prime function of the Speaker to guide the deliberations of this body and facilitate the transaction of business in an orderly and harmonious manner in accordance with the rules of parliamentary procedure. The latter rules are the bulwark of the democratic process and the mainstay of substantive rights. They guarantee to each member the right to propose motions; the right to free and full discussion of every proposition presented for decision; the right to disagree and dissent. The rules of parliamentary procedure place absolute authority in the members of the assembly to change the course of an action—by a motion to amend or to refer or to postpone indefinitely. If the assembly grows weary of long and repetitive debate, it may on its own initiative move to limit debate or to vote immediately or to postpone temporarily by laying on the table.

In this very democratic process, there is but one autocrat—and he is the Speaker. By the very nature of his position as mentioned above, authority is vested in him to rule on matters of procedure, to recognize members who wish to address the chair, to render decisions on incidental motions, interpret the rules, etc. But democracy once again rears its protective head by placing the final authority in the hands of the members of this assembly because any member who believes the Speaker to be mistaken or unfair in his ruling may appeal such ruling to the full House for its verdict. Likewise, any member who has doubts as to the accuracy of the Speaker's decision regarding the prevailing side on a voice vote has the perfect right to ask for a head count by means of a rising vote. Even more emphatic, a Speaker who uses his authority to awe, entangle or confound the House—can be replaced by the same democratic process that elected him. So you see that there is a happy blend of authority—the Speaker must use his authority wisely, and he must be flexible and bend to the will of the House.

Now just a few words about the Reference Committees. These Committees, established by the By-Laws of the FMA, are an integral part of this meeting and created for the purpose of facilitating the work of the House of Delegates. All matters presented to the House are referred to these Committees for open hearings and discussions and debate. Delegates and Association members are urged to appear before these Committees to express their views on particular proposals, whether it be approval, comments, criticism, opinion or dissent, so that the recommendations of the Reference Committees to the House of Delegates will represent the broadest cross-section of views of the membership as possible. The time and meeting-place of each Reference Committee is published in your Handbook, as well as the reports and resolutions to be considered and debated. Please review these carefully and diligently and appear before the Reference Committee if you feel your comments or criticism will aid these Committees in recommending the best course of action to be taken by the voting body. The final Reference Committee reports will be available to each Delegate before the second session of the House.



Finally, please remember that the Speaker and Vice-Speaker are your officers elected by you to serve you. Our purpose is and our aim will be to expedite the business before this Assembly as fairly, as concisely, as harmoniously as possible. We will be available to you to assist you in any way possible. If you need help . . . try us.

Thank you.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

The Speaker introduced distinguished guests: Mrs. James J. DeVito, President, and Mrs. W. H. Mathews, President-Elect, Woman's Auxiliary to the Florida Medical Association; Mrs. Robert F. Beckley, President, Mrs. Linus Hewit, Director and Chairman of the Health Education Committee, and Miss Hazel Lewis, Assistant Executive Secretary, Woman's Auxiliary to the American Medical Association.

Mrs. DeVito greeted the House and commented on the many accomplishments of the Auxiliary over the past year. She stated that the "real winner" for the year was the tremendously successful Statewide Health Education Conference which was held in St. Petersburg in March. Through the combined efforts of the physicians of Florida, the staff of the Florida Medical Association and the Auxiliary, the Conference concerning the problem of youth and a comprehensive plan for health education was truly a highlight of the year. Mrs. DeVito expressed her appreciation for all those who cooperated with the Auxiliary in this effort.

Mrs. DeVito stated that the Auxiliary can make a great impression representing the physicians in areas where time just does not allow them to do their own representation.

Mrs. DeVito closed with an invitation to visit the Auxiliary's First House of Delegates, Thursday, May 10.

President Dean then introduced Mr. Jack W. Herbert, President, Blue Shield and Blue Cross of Florida and the Honorable Earl Hadlow of Jacksonville, President-Elect, The Florida Bar.

Mr. Hadlow briefly commented on the relationship of the two professions, medicine and law. He stressed that with their background of the finest education and social standing they should work together to devise new systems to improve the state of the nation.

He urged physicians to "gear up" and involve themselves in every aspect of society and to assume a larger role in the community. Mr. Hadlow closed with the charge that "let's none of us



The Honorable Earl Hadlow of Jacksonville, President-Elect, The Florida Bar addresses the First House of Delegates.

ever back away; let's not be pessimistic; let's not fail to challenge, question, attack, fight! Let's never give up 'til the quality of life in this country suits us absolutely and until we honestly believe that we—you and I, personally—have done every last thing we can do to make it so!"

Dr. Dean requested that Dr. Yank D. Coble Jr. and Dr. John A. Rush Jr. escort Dr. Sanford A. Mullen to the podium, and expressed his pleasure upon presenting to Dr. Mullen the 1973 A. H. Robins Company Annual Award "For Outstanding Community Service by a Physician."

#### A. H. Robins Company Award

"FOR OUTSTANDING COMMUNITY SERVICE  
BY A PHYSICIAN"

Sanford Allen Mullen, M.D., of Jacksonville, whose life seems to be dedicated to civic improvement and good causes, has been selected by the Board of Governors of the Florida Medical Association to receive the 1973 A. H. Robins Company Award for Outstanding Community Service by a Physician.

Each year, the Board faces the difficult task of singling out a member of the Florida Medical Association for this honor from nominees proposed by FMA's county medical societies. Recipients are selected on the basis of services rendered to their communities.

A mere glance at the long list of Dr. Mullen's list of activities and accomplishments leaves no doubt that he has given generously of himself to his profession, and to the cultural, civic and social wellbeing of his native Florida and his beloved Jacksonville.

Sanford Mullen was born in Tampa 48 years ago and received his early education in the public schools there and at Jacksonville. After attending Mercer University, Dr. Mullen realized a childhood dream when he received the degree of Doctor of Medicine from the Columbia





Dr. Sanford A. Mullen, Jacksonville, accepts the A. H. Robins Company Award "For Outstanding Community Service by a Physician," from Dr. Dean.

University College of Physicians and Surgeons. He chose the specialty of pathology and holds the diploma of the American Board of Pathology.

He entered the practice of pathology in Jacksonville in 1958, and at the present time he serves as Executive Vice President and Medical Director of the Jacksonville Blood Bank.

An active participant in organized medicine, Dr. Mullen is, among other things: President-Elect of the Duval County Medical Society (which recommended him for this honor); Chairman of the Council on Legislation and Public Agencies of the Florida Medical Association; Past President of the Academy of Medicine of Jacksonville; Trustee of the Jacksonville Hospitals Education Program; President-Elect of the Florida Association of Blood Banks; President of the Florida Society of Pathologists; and a member of the Board of Governors of the College of American Pathologists.

Because of his high professional standing, he has been selected to serve on various scientific advisory committees to the Florida State Board of Health, Florida State Department of Education and Florida Junior College of Jacksonville.

As impressive as Dr. Mullen's professional credentials are, his civic and charitable activities are equally imposing, and it is for the latter that he was picked for this honor.

In this regard, it might be said that Dr. Mullen's interests range from "A" (for Arthritis Foundation) to "Z" (for Zoological Society).

His activities on behalf of The Arthritis Foundation have included terms as President of both the Duval County Division and the Florida Chapter, and as a member of the Board of Governors of the national organization. He also sits on the Board of the Jacksonville Zoological Society.

In between, he has apportioned his time and talents to such organizations as the Duval County Chapter, American Cancer Society (small business campaign unit chairman); Northeast Florida Heart Association (Board of Directors); Florida Division, Salvation Army (Advisory Board); United Fund of Jacksonville (chairman, physicians' campaign); Northeast Florida Kidney Foundation (Board of Directors); Jacksonville Chapter, American Red Cross (Board of Directors) and the Cathedral Foundation (Executive Vice Chairman).

He also has managed to find time to serve a year as President of the Rotary Club of Jacksonville and to be active in the Jacksonville Area Chamber of Commerce, which he has served in various capacities, including Vice President and member of the Board of Governors.

He has served his city government as a member of the Mayor's Permanent Advisory Committee on Water Pollution Control and as Vice Chairman of the Water Quality Control Board.

Equally interested in the arts, Dr. Mullen has served as Vice President of the Jacksonville Symphony Association and on the Membership Committee of the Cummer Gallery of Art. He also is associated with the Jacksonville Art Museum.

Dr. Mullen's endless efforts to improve his community have earned for him: (1) a Distinguished Service Award from The Arthritis Foundation; (2) a Special Award from the Jacksonville Earth Week Committee for Protection and Improvement of our Environment; and (3) a Membership and Development Award from the Jacksonville Area Chamber of Commerce.

The Robins recipient's military service spanned a total of more than 20 years. He was retired with the rank of Commander (Medical Corps) in the U.S. Navy Reserve.

Dr. and Mrs. Mullen, the former Minnie Lucille Woodall, are parents of three boys: Sanford Allen Jr., 21; Henry Woodall, 19; and Michael Hill, 15.

Dr. Mullen expressed his personal pleasure and gratification in receiving the award. He then introduced his wife, Minnie, and son Michael, and commented that his other two sons were studying, "I hope," at Mercer University.

Dr. Dean then presented his annual address. (The text of Dr. Dean's address begins on page 21.)

Dr. Dean recognized the FMA Executive Vice President, W. Harold Parham, who received a standing ovation.

Dr. Dean recognized Dr. Louis C. Murray, commending him for his excellent service on the State Board of Regents during which time he was very active and represented the people in such a way that made the doctors of Florida real proud.

Dr. Dean then introduced his wife, Polly, and his secretary, Mrs. Mary Louise Merrill.

The Speaker announced the appointment of delegates to the Reference Committees, who had been appointed by the Speaker in consultation with the President, on the basis of five members for each Reference Committee, one from each of the four medical districts and one from the membership of the House at large. The Speaker also announced assignment of an AMA delegate as advisor to each Reference Committee, and the time and place of the meetings of the Reference Committees on Thursday, May 10:

Reference Committee No. I—Health and Education

10:00 a.m., Meeting Room A

William M. Straight, Chairman  
John T. Blackburn  
F. Norman Vickers  
Thomas M. McKell  
Paul C. Harding  
Rufus K. Broadaway, AMA Delegate Advisory

Reference Committee No. II—Public Policy

10:30 a.m., Meeting Room D.

Charles F. Tate Jr., Chairman  
Edward W. Stoner  
Robert N. Webster  
Roger A. Laughlin  
Andre S. Capi  
Richard G. Connar, AMA Delegate Advisory

Reference Committee No. III—Finance and Administration

11:00 a.m., Medallion Room

William W. Thompson, Chairman  
Joseph P. Hendrix  
Howard M. DuBose  
Carl E. Andrews  
O. William Davenport  
Samuel M. Day, AMA Delegate Advisory

Reference Committee IV—Legislation and Miscellaneous

10:30 a.m., Meeting Room C

Frank C. Coleman, Chairman  
John A. Rush Jr.  
Henry L. Harrell  
Curtis W. Cannon  
Charles A. Monnin  
Burns A. Dobbins Jr., AMA Delegate Advisory

Reference Committee V—Medical Economics

10:00 a.m., Meeting Room B

Miles J. Bielek, Chairman  
William W. O'Connell  
John N. Carlson  
Milton E. Lesser  
Hoke H. Shirley Jr.  
Robert E. Zellner, AMA Delegate Advisory

The Vice Speaker, Dr. Murray, advised that if there was no objection reports and resolutions would be assigned as published in the Handbook. No objection was raised. The House's attention was called to the referrals of supplemental reports and resolutions which had been distributed in the Delegates' packets.

The Speaker asked if there were any report from the floor. None were presented.

The Speaker announced the Blue Shield Annual Meeting to be held Thursday, May 10, 8:00 a.m. in the Medallion Room and the AMA Delegates Reference Committee, Friday morning, 9:00 a.m., Westward Room V.

It was announced that the President's guest speaker at the General Session, to be held Friday, May 11, at 11:00 a.m., would be Dr. Russell B. Roth, President-Elect of the AMA, and that Senator John Tower of Texas would be the speaker at the Joint FLAMPAC and FMA Woman's Auxiliary Luncheon scheduled for Friday, May 11, at 12:15 p.m.

The President announced that a Prayer Breakfast would be held Sunday morning at 8:00 a.m. in the Floridian Room and urged all the physicians and their families to attend.

It was also announced that the Florida Physicians Association would have a Board meeting at 5:00 p.m., Thursday, May 10 in the Westward V Room, with a general membership meeting to follow at 5:30.

Dr. James L. Borland Jr. announced that there would be a PSRO panel held Saturday morning, 11:00 a.m. in Meeting Room D.

The First House of Delegates recessed at 6:05 p.m., to reconvene on Saturday, May 12 at 3:00 p.m.



# Second House of Delegates

The second meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 12, 1973, in the Bal Masque Room of the Americana Hotel, Bal Harbour, with Dr. Franklin J. Evans, Speaker of the House, presiding.

Dr. Nikolaus reported 182 delegates registered, constituting a quorum and it was moved that the House be seated. The motion carried.

## Delegates

ALACHUA—Allen Y. DeLaney, David M. Drylie, Charles H. Gilliland, George W. Little, George H. Miller Jr., Gerold L. Schiebeler.  
 BAY—James Phillips, W. C. Roberts.  
 BREVARD—John T. Blackburn, Michael J. Foley, Edwin E. Hadden Jr., T. John Kaminski, Robert C. Seelman.  
 BROWARD—Andre S. Capi, Milton P. Caster, Yale Citrin, Richard S. Doyle, Joseph E. Gelety, Ray E. Murphy Jr., Frank B. Ott, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Dan C. Smith, John I. Williams (Absent—Miles J. Bielek, Russell B. Carson, Leonard A. Erdman, F. Gary Gieseke, John R. Mahoney).  
 CHARLOTTE—Melvyn J. Katzen.  
 CLAY—Laurin G. Smith III.  
 COLLIER—Foster L. Bullard Jr., Hoke H. Shirley Jr.  
 COLUMBIA—John T. Wilson.  
 DADE—Jerome Benson, Rufus K. Broadaway, Harvey E. Brown Jr., Manuel L. Carbonell, Richard C. Clay, Jack Q. Cleveland, A. J. Fernandez Conde, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, Dewitt C. Daughtry, O. William Davenport, Joseph H. Davis, Richard C. Dever, Robert F. Dickey, J. Lee Dockery, Charles A. Dunn, Miguel Figueroa Jr., Richard M. Fleming, M. Eugene Flipse, Marshall F. Hall, Henry C. Hardin, Joseph Harris, James J. Hutson, Walter C. Jones III, Maurice H. Laszlo, Carlos G. Llanes, Rose E. P. London, Seymour B. London, Ronald J. Mann, Ildefonso R. Mas, Bruce E. Miller, Charles A. Monnin, Sheldon D. Munach, Jorge R. Pena, Julian A. Rickles, Ronald H. Scherr, Janice K. Sherwood, Everett Shocket, William M. Straight, Charles F. Tate Jr., Maynard F. Taylor, Elliott Witkind, Arthur W. Wood Jr., Scheffel H. Wright, Sheldon Zane (Absent—John O. Brown, Edward W. St. Mary, Daniel L. Seckinger II, Robert E. Willner).  
 DESOTO-HARDEE-GLADES—Calvin W. Martin.  
 DUVAL—Warren M. Barrett, James L. Bo-land Jr., Yank D. Coble Jr., Clyde M. Collins, Emmet F. Ferguson Jr., Stephen P. Gyland, Millard F. Jones, Leonard E. Masters, Charles B. McIntosh, Faris S. Monsour Jr., Thad M. Moseley, Sanford A. Mullen, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander.  
 ESCAMBIA—Charles J. Kahn, Theodore J. Marshall, Philip B. Phillips, William M. C. Wilhoit (Absent—F. Norman Vickers).  
 FRANKLIN-GULF—Joseph P. Hendrix.  
 HIGHLANDS—(Absent—Donald C. Hartwell).  
 HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Irving M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Richard S. Hodes, Thomas E. McKell, W. Mahon

Myers, William W. Trice, Harold L. Williamson (Absent—Curtis G. Rorebeck).  
 INDIAN RIVER—Daniel Thornton (Absent—J. C. Robertson).  
 LAKE—Fred C. Andrews, Thomas D. Weaver.  
 LEE—Larry P. Garrett, J. Stewart Hagen III, F. Lee Howington.  
 LEON-WAKULLA-JEFFERSON—Edward G. Haskell Jr., Nelson H. Kraeft, Robert N. Webster.  
 MADISON—(Absent—Johnson Bibb).  
 MANATEE—John D. Lehman, Roger A. Meyer, Millard P. Quillian.  
 MARION—Henry L. Harrell (Absent—C. Brooks Henderson).  
 MONROE—Ronald H. Chase.  
 NASSAU—Marshall E. Groover.  
 OKALOOSA—(Absent—William W. Thompson).  
 ORANGE—Norman F. Coulter, Edward L. Farrar, Eugene N. Forrester, Clifford L. Garrard Jr., Paul C. Harding, M. Herbert Martin Jr., Joseph G. Matthews, Franklin B. McKechnie, Franklin G. Norris, James F. Richards Jr., Edward W. Stoner, Thomas B. Thames.  
 OSCEOLA—George A. Gant.  
 PALM BEACH—Willard F. Ande, Carl E. Andrews, Vernon B. Astler, Curtis W. Cannon, James F. Cooney, Jerry F. Cox, George L. Ford Jr., J. Russell Forlaw, Bernard Kimmel, Richard B. Moore, Dick L. Van Eldik.  
 PANHANDLE—William F. Brunner.  
 PASCO-HERNANDO-CITRUS—James P. Gills Jr., Randall W. Jenkins.  
 PINELLAS—Charles K. Donegan, James C. Fleming, Walter W. Hamilton, Daniel S. Hellman, Roger A. Laughlin, Jack A. MaCris, William G. Mason, Walter S. McKeithen Jr., James H. Miller Jr., Donald G. Nikolaus, David T. Overbey, Thomas M. Quehl, Rowland E. Wood.  
 POLK—Marvin G. Burdette, J. Gerard Converse, Howard M. Dubose, John W. Glotfelty, Willard E. Manry, Frank Zeller Jr.  
 PUTNAM—Roy E. Campbell.  
 ST. JOHNS—W. W. O'Connell.  
 ST. LUCIE-OKEECHOBEE-MARTIN—Howard C. McDermid, John F. Powers.  
 SANTA ROSA—(Absent—Claude J. Barnes).  
 SARASOTA—John N. Carlson, George M. Coggan, F. H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.  
 SEMINOLE—Luis Perez.  
 SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Hugo F. Sotolongo).  
 TAYLOR—John A. Dyal.  
 VOLUSIA—Octavius B. Bonner Jr., William E. Carter, Charles A. Stump (Absent—Thomas W. Ayres).  
 WALTON—(Absent—Howard F. Currie).  
 SPEAKER OF THE HOUSE—Franklin J. Evans.  
 VICE SPEAKER OF THE HOUSE—Louis C. Murray.

Dr. Dean assumed the Chair to make presentations to the medical school deans of unrestricted contributions from the AMA-ERF. He asked the deans to come forward to accept the checks.

Dr. Chandler A. Stetson, Dean, accepted the contribution for the University of Florida College of Medicine in the amount of \$4,495.81. Dr. Donn



L. Smith, Dean, accepted the contribution of \$2,501.63 on behalf of the University of South Florida College of Medicine. A check for \$3,818.01 was presented to Dr. E. M. Papper, Dean, for the University of Miami School of Medicine.

The Speaker, Dr. Evans, reported to the House that fifty-six members had departed this life during the past year. In memory of these physicians

roses have been placed in the vases at each end of the Speaker's podium. Everyone was asked to rise for a moment of silent prayer in respect for the loss of their colleagues.

Dr. Evans called everyone's attention to the fact that Palm Beach County delegates were all attired in jackets of the same color.

## Report of AMA Delegates Reference Committee

Dr. Francis T. Holland, Chairman of the AMA Delegates Reference Committee, came forward to give the report of the committee.

Dr. Holland's report was received as information.

The Reference Committee met with all delegates and alternates who were present at the Convention. In addition we had Dr. Jere Annis, a member of the Board of Trustees from Florida, and Dr. Russell B. Roth, President-Elect of the AMA.

The attendance at this meeting was very limited but questions were raised that we think are important. It was brought out that some doctors do not feel that the delegations were properly representing the men at the grass roots. Also, it was apparent that there was some feeling that the AMA was responsible for the PSRO law. This was certainly not true. The AMA fought the PSRO from its inception until its becoming a law by its passage through Congress.

We are indeed sorry that we did not have greater participation because this was a meeting for each of you to air your gripes about the AMA for I am sure you do not agree with all of the actions and policies of this Association. Neither do we, your delegates, who are elected to represent you. The same applies in this House of Delegates here. There will be actions taken here with which you may violently disagree, but this is the action of your democratic organization and we all join hands after action is taken and attempt to make it work. If you feel that it will not work, you will continue to work through your own Association to make this change at a subsequent session.

We were appalled to learn that doctors do not know that each of you have a mechanism to take your grievances and gripes to the AMA.

1. If you have an idea that you feel should be taken to the AMA, you can present it to your county medical society and if they in turn agree with you, it will be presented to this House of Delegates and if it passes

this House we are mandated to take it to the AMA and present and fight for this both in reference committee and on the floor of the House, whether we individually or collectively agree or disagree with the resolution. This we have done on several occasions.

You also have the right, whether you are a delegate or not, to appear before the reference committee of your Association and also before the reference committee of the AMA to present your view.

2. Another route of presentation of your ideas to the AMA is to present them to your specialty organization and this in turn will be presented to the House of Delegates from that section.

3. If you have not been successful in this route, and can convince any member of the Florida delegation, they can take this and present it as an individual resolution and you still have the right to appear before a reference committee.

Each of us would be willing to appear before your county medical society to present information concerning the AMA and to answer any questions that you or your society might desire.

If at any time, you feel that any of us do not fairly represent you and the Florida Medical Association, you have the right and it is your duty to select someone that you feel will carry out your ideas and push for his election, as each of us come up for re-election every two years.

We find that many think that being a delegate to the AMA is all fun and no work. Let me point out to you that our delegates' handbook is more than 10 times the size that you have here. We have to go through it prior to the meeting; and before the first session convenes, we caucus and go over the ideas that we feel are important to Florida, and we assign one member, delegate or alternate, to attend a reference committee. He will be responsible to bring back to the entire delegation information concerning the actions of that committee for us to discuss as to whether we will endorse the report of the reference committee or vote against the reference committee, or even on occasion, be a split delegation. We also caucus each morning during the session at 7:00 a.m. for our discussions and anticipated actions.

# Report of Reference Committee No. I

## Health and Education

Dr. William M. Straight, M.D., Chairman of Reference Committee No. I, came forward to present the report of his committee.

### Council on Scientific Activities

The Reference Committee proposed the following amendments to the report of the Council on Scientific Activities.

After careful consideration and listening to the criticisms that the specialty societies had not had the opportunity to consider in detail all aspects of Recommendation No. 1, the Reference Committee felt that the recommendation would serve as a starting point which could later be amended after due consultation with the specialty societies, and therefore recommended adoption as presented.

The recommendation was adopted.

As recommended by the Reference Committee, Recommendation No. 2 was adopted.

The Reference Committee recommended that Recommendation No. 3, along with the Board of Governors Action regarding FMA membership for medical students and the Judicial Council Report regarding medical student membership be referred to the Board of Governors for further consideration by the Judicial Council and the Council on Scientific Activities, as there seem to be conflicts in the actions of these bodies.

Recommendation No. 3 was referred to the Board of Governors.

The Reference Committee recommended that Recommendation No. 4 be amended by deleting all but the following wording: "That the Association recognize the significant contributions made by the Florida Regional Medical Program, particularly during the past two years."

The amendment was adopted, and Recommendation No. 4 was adopted as amended.

The report of the Council on Scientific Activities was adopted as amended.

### Council on Scientific Activities

JAMES M. INGRAM, M.D., *Chairman*

The 1972-73 year was a significant one in the Council's areas of responsibility. The Committee on Continuing Medical Education developed guidelines and mechanisms for complying with the continuing education requirement for maintenance of Association membership. The Committee on Medical Students worked out a format for medical student membership in the Association. The Committee on Scientific Assemblies, in cooperation with the state specialty societies, put together the largest and most varied annual meeting scientific program in the Association's history. Due to economies in federal spending, the future of the Florida Regional Medical Program as of this report appears rather dim.

In addition to considering the aforementioned developments, the entire Council also:

(1) Undertook action to implement a recommendation of the 1972 House of Delegates that the offices of coordinator and president of the Florida Regional Medical Program be separated, although such action must now be viewed in the perspective of a possible impending phasing out of the program.



William M. Straight, M.D., Miami (standing) was Chairman of Reference Committee I. His Committee included (left to right): John T. Blackburn, M.D., Melbourne; F. Norman Vickers, M.D., Pensacola; Paul C. Harding, M.D., Orlando and Thomas M. McKell, M.D., Tampa. Mrs. Sharyn Dennis served as secretary to the Committee.



(2) Noted that Dr. Donn L. Smith, director of the medical center and dean of the University of South Florida College of Medicine, was designated as the Association's delegate to the U.S. Pharmacopoeial Convention of 1973.

(3) Encouraged the Committees on Scientific Assemblies and Continuing Medical Education to study the continuing education aspects of the annual meeting scientific program with a view towards making the annual meeting a prime opportunity for physicians to obtain credits for membership maintenance requirements.

(4) Authorized and encouraged the Committee on Scientific Assemblies to meet jointly with the program chairmen of specialty groups to bring about earlier completion of the annual meeting scientific program.

(5) Recommended to the Board of Governors that the annual dinner honoring the deans of Florida's medical schools be continued.

(6) Agreed that following adoption and implementation of the procedures for fulfilling the new membership continuing education requirement, the Association should proceed quickly to establishing itself as a state "clearing-house" for continuing medical education programs.

(7) Considered and concurred in a recommendation from the Council on Medical Services that a school of public health be established in Florida.

(8) Evaluated the scientific and educational aspects of the annual meeting and made appropriate recommendations to the Board of Governors.

(9) Considered the progress and problems of the *Journal of the Florida Medical Association* as a scientific publication and made needed recommendations to the Board of Governors.

The Council met formally on March 3, 1973, to consider the reports and recommendations of each of its committees. Each individual committee's activities will be briefly summarized in this consolidated Council report, which will be concluded with recommendations adopted by the Council. Other recommendations for action by the Board of Governors were made separately to that body and they will be included in its annual report.

The Committee on Continuing Medical Education held a series of meetings during the year to develop the procedures being recommended for fulfilling the new continuing education requirements for maintenance of Association membership. Numerous future meetings are anticipated as this important program moves into implementation. The committee also found time to study other portions of its varied responsibilities and to keep abreast of developments in this rapidly changing field.

The Committee on Medical Schools was not as active as in past years due largely to its lack of success to date in securing official recognition as advisory body to the Board of Regents of the State University System in its expanded role as the Florida Joint Commission on Medical Education. Recommendations in this regard were formulated by the Council.

The Committee on Medical Students met jointly with medical student leaders at the medical schools and developed a set of criteria for medical student membership in the Association. If adopted, the criteria will be translated into appropriate by-laws amendments to make student membership a reality for the benefit of the Association and the medical students.

The Committee on Regional Medical Program maintained close liaison with the Florida Regional Medical Program and kept informed of its activities.

The Committee on Research continued its function as a review and evaluating mechanism for the Florida Medical Foundation for medical research grant applications.

The Committee on Scientific Assemblies, in cooperation with participating state specialty societies, developed the 1973 annual meeting scientific program which has a record 34 scientific section programs. The committee also evaluated and selected scientific exhibits from a large number of applications from throughout the state and nation.

The Committee on Scientific Publications continued to supervise the publication of the *Journal of The Florida Medical Association* and to work towards improving its quality as a scientific and educational medium responsive to the needs of Florida physicians. A special Association centennial issue is planned for January, 1974.

## RECOMMENDATIONS

1. That the following procedures for fulfilling the continuing education requirement for maintenance of Association membership be adopted:

- (1) Ninety (90) hours of continuing medical education within a 3-year period will be required for maintenance of regular active Association membership. All the hours may be obtained in any one year.
- (2) The American Medical Association's Physician's Recognition Award and the American Academy of Family Physicians Certificate of Education will be acceptable for fulfilling the regulations. As other certifications are developed they will be considered for acceptance by the FMA Committee on Continuing Medical Education.
- (3) Extenuating circumstances preventing an individual from obtaining the required hours of continuing education will be considered by the Committee on Continuing Medical Education.
- (4) Hour for hour credit will be given for participation in an acceptable course or as stated for that program.
- (5) Hours required for maintenance of membership will be classified in the following manner:

### A. Mandatory hours (at least 60 hours)

- a. Fifty (50) credit hours will be allowed for a full year of internship, residency, fellowship or research.
- b. Postgraduate courses approved by the FMA, AMA or AAFP and/or those sponsored by medical schools.

- ### B. Elective hours (no more than 30 hours)
- Credit will be given for participation in scientific hospital meetings, county medical society meetings and personal continuing education activities such as listening to tapes, journal clubs and library reading on an hour for hour basis. Such activities must be listed as to time and title. Evidence of registration in meetings must be presented whenever possible.



## PROCEDURES FOR FILING REQUIRED INFORMATION

- (1) Forms will be furnished by the FMA to each member beginning December, 1973 for furnishing evidence of continuing medical education beginning January 1, 1974.
- (2) Each subsequent year a duplicate form will be furnished by the FMA to have added hours entered.
- (3) The end of the first three-year period will be December 31, 1976 and all members will be required to report at that time for the entire period.
- (4) Reporting forms may be submitted to and through those component county medical societies wishing to certify members' fulfillment of the continuing medical education requirements.

## APPEAL PROCEDURES

### Method for Appealing

If at the end of a reporting period a member has been informed that he has insufficient credit, and disagrees with this decision, he may.

- a. First appeal for adjustment to his county medical society and/or the Committee on Continuing Medical Education. He may do this in person or by letter.
- b. If the member does not agree with the decision of the Committee on Continuing Medical Education, he may further appeal to the Board of Governors. The Board of Governors will have final decision in such matters.

### Failure to Meet the Requirements

- (1) If, at the end of the reporting period, insufficient credit has been accrued by the member and an appeal to the Board of Governors through the Committee on Continuing Medical Education has been denied, the member will be informed in writing of that determination.
- (2) The Committee on Continuing Medical Education will then give the member notice of a hearing.
- (3) At the hearing the Committee shall give the member ample opportunity to be heard and he may consult with specialists in the same field.
- (4) If the Committee on Continuing Medical Education determines that the requirements have not been met, they will so inform the member and recommend to the Board of Governors that the member be suspended. The Board of Governors will make all final decisions and will so notify the member.

## Make-up of Delinquent Credits

- (1) A member may complete the requirements at any time during the year following the 3-year reporting period and if accepted by the Committee on Continuing Medical Education, he shall be certified for the preceding period without effect on his membership status.
  - (2) The credits accrued during this extended period will not be accepted as credit for the following reporting period.
2. That the Association make every possible effort to have one or more medical doctors on the Board of Regents of the State University System, to be nominated in consultation with the Association, and that an official action be obtained from the Board of Regents designating the Florida Joint Commission on Medical Education as a medical advisory body to the Board.
  3. [REFERRED TO BOARD OF GOVERNORS] That the following criteria for medical student membership in the Association be adopted:
    - a. That a category of medical student membership in the Association be established.
    - b. That eligibility be restricted to students who have matriculated in a Florida medical school.
    - c. That student membership be through the local component county medical society in the area of each medical school.
    - d. That student members have all the rights and privileges of active members except that of holding elective office.
    - e. That each local county medical society in the area of a medical school be requested to develop some mechanism whereby one student delegate to the Association's House of Delegates may be elected without diluting the usual number of active delegates from such society.
    - f. That Association student membership not be attached to membership in any other organization, such as the Student American Medical Association.
    - g. That student membership dues be \$10 per year.
  4. That the Association recognize the significant contributions made by the Florida Regional Medical Program, particularly during the past two years.

**Resolution 73-16**  
**Medicaid Screening Programs**  
**Alachua County Medical Society**

The Reference Committee recommended that Resolution 73-16, Medicaid Screening Programs, be amended by deleting the words, "of Medicaid children." An amendment was moved from the floor to change the wording to "... be apprised of any impending health screening and. . ."

The amendment from the floor carried and Resolution 73-16 was adopted as amended.

**Resolution 73-16**  
**Medicaid Screening Programs**

RESOLVED, That the Florida Medical Association requests that the component medical societies in Florida be apprised of any impending health screening and given the opportunity to advise and participate in such screening in the interest of providing the best possible quality medical care.

**Council on Specialty Medicine**

The Reference Committee recommended that Recommendation No. 2 of the Council on Specialty Medicine Report be deleted and the "Resolved" portion of Resolution 73-16, as amended, be substituted for this recommendation.

The recommendation of the Reference Committee was adopted.

The report of the Council on Specialty Medicine with the exception of Recommendation No. 1 was adopted as amended.

**Council on Specialty Medicine**

FREDERICK C. ANDREWS, M.D., *Chairman*

The House of Delegates at its meeting in 1972 approved recommendations of a special FMA ad hoc committee to review the structure of the FMA altering the composition and structure of the Council on Specialty Medicine. As directed by the House, representatives of FMA recognized specialty groups have been appointed to the Council by their individual specialties; and the Council on Specialty Medicine has throughout the Association year, 1972-73, pursued its new responsibilities as directed by the House. There are many new faces on the Council and attendance at the three meetings held during the year has been good. The meetings held were on September 10, and December 17, 1972, and on February 25, 1973. Many items were reviewed which will be summarized in this report and most of the recommendations that were forthcoming from the Council's deliberations have been acted on by the Board of Governors.

The newly organized Council has developed into a cohesive cooperative group concerned and responsive to the needs of organized medicine in the state. Most importantly, the Council is eager to carry out its responsibilities in providing harmony and coordination to the general body of medicine in Florida, to be truly representative of and an effective liaison link between the FMA and the specialty groups.

Activities—In July of 1972, the Council received a request from the FMA Executive Committee for a review and recommendations to further clarify the functions of the Council on Specialty Medicine as directed by the House of Delegates.

The Council expressed its agreement that all activities of the FMA involving recognized specialty groups should be coordinated through the Council on Specialty Medicine—in particular, the FMA Annual Meeting program, post-graduate education, coordination with specialty groups with regard to the FMA Legislative Program, etc. The Council outlined what it thought should be its basic goals and functions and has received approval from the Board of Governors for the following:

- A. That the Council on Specialty Medicine serve as the liaison between the Florida Medical Association and the FMA recognized specialty groups in the state.
- B. That the Council on Specialty Medicine be advised of new programs and projects originating in the FMA or specialty groups.
- C. That the Council on Specialty Medicine be one of the major sources of communication between the representative groups.
- D. That the members of the Council on Specialty Medicine be a part of or have liaison with the Council on Scientific Activities and its committees.
- E. That the Council on Specialty Medicine act as mediator between specialty groups and the FMA when such need occurs.
- F. That the FMA Legislative Program be presented to the Council on Specialty Medicine for their recommendations and dissemination as information to the individual specialty groups of the Council.
- G. That the Council on Specialty Medicine investigate with the appropriate agencies the distribution of physicians in Florida by specialty, both geographically and in proportionate ratio to population, and advise and make recommendations to the medical schools and other agencies based on these findings so that we may properly achieve an ideal distribution of medical specialists throughout the state.

The Council has endeavored to carry out the directions of the House of Delegates by:

- A. Urging specialty groups to appoint annual meeting scientific program chairmen two years in advance and offering assistance to the Committee on Scientific Assemblies in planning the FMA Annual Meeting Scientific Program.
- B. Urging each specialty group to be certain that its aims do not conflict with established FMA policy and that all groups voice their opinions or disagreements with FMA policy through the Council.

The Council received approval from the Board for appointment of two ad hoc committees. The first committee has been charged with reviewing the makeup of the Council when an individual specialty is represented by more than one recognized specialty group. This matter is still under consideration by the committee. The committee was also requested to review a problem regarding a conflict with FMA policy that members of recognized specialty groups be members of FMA. The Council has expressed its full support of current FMA policy that one of the criteria for recognition of specialty groups be that their members be required to be members of the FMA. The committee additionally has under review applications from several specialty groups seeking recognition. The Council on Specialty Medicine has responsibility for reviewing applications for recognition and making recommendations to the Board of Governors.

A second ad hoc committee has been appointed to continue and complete the study initiated by the FMA Judicial Council regarding hospital-based physicians billing practices. Separate billing has been a long-standing objective; and the committee has just begun to review a large volume of statistics and reports compiled by the Judicial Council. Pending further study and recommenda-



tions, the Council has recommended that current FMA policy be reaffirmed, urging all hospital-based physicians, who are currently on combined billing, to convert to separate billing arrangements with the hospitals.

Another important matter that came before the Council was the possible establishment of a school of optometry in the state. Representatives from the Florida Society of Ophthalmology presented detailed reports which clearly indicated that at the present time there is no need for a school of optometry in the State of Florida; and the Council has recommended that the FMA oppose any legislation to establish such a school.

The following is a summary of additional actions taken by the Council:

- A. Expressed support for state funding for the Medical Examiners Commission.
- B. Passed a resolution expressing the regret of the Council over the untimely death of Dr. Alfred L. Lewis of Tallahassee. Dr. Lewis was the representative of the Florida Society of Pathologists on the Council and had served organized medicine at all levels in an exemplary manner.
- C. Appointed, with approval of the Board, one of the Council's representatives, Dr. William J. Hutchison, to serve as liaison with the FMA Council on Legislation and Public Agencies. The purpose is to improve communications between FMA and the specialty groups and to provide better coordination for legislative efforts in Tallahassee and nationally. Additionally, the Council called on all recognized specialty groups, when contemplating action regarding legislation, not to undertake independent action without conferring with the FMA. Each specialty group has also been urged to appoint an official legislative contact.
- D. The Council has recommended support of the American College of Emergency Physicians' request for sectional status within the AMA.
- E. The Council has recommended approval of a resolution from the Florida Pediatric Society for adequate funding by governmental agencies of medical screening programs and that all such programs be monitored by and under the direct supervision of the county medical societies. This action resulted from the knowledge of recent inadequate funding of a screening examination of children under Medicaid in Alachua County which resulted in inferior service.
- F. Approved in principle the FMA undertaking sponsorship of preceptorship programs in various specialties for medical students in Florida's medical schools.
- G. Approved in principle the establishment of 30 hours of continuing medical education as a minimum requirement for maintaining FMA membership and has recommended that the Council on Specialty Medicine be given the opportunity for input before final requirements for individual specialties are determined.

The Council has made recommendations to the Board of Governors for By-Laws changes affecting the composition of the Council, including a recommendation that the Council be composed of one representative from each recognized specialty rather than each approved society and also that at the time approved specialties appoint their representatives to the Council, they select alternate representatives.

## RECOMMENDATIONS

1. That the Florida Medical Association oppose the establishment of a school of optometry in the State of Florida at the present time by adopting the following resolution: (amended-R. C. IV)

Whereas, Chapter 463.01 of the Florida Statutes defines the practice of optometry as follows, "To be the diagnosis of the human eye and its appendages, and the employment of any objective or subjective means or methods for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological or anatomic anomalies of the human eyes and their appendages, and the prescribing and employment of lenses, prisms, frames, mountings, orthoptic exercises, light frequencies and any other means or methods for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages," and further defines an optometrist as, "one who practices optometry in accordance with the provisions of this chapter," and

Whereas, this chapter of Florida law could be interpreted as promoting the practice of medicine, and

Whereas, present statistics do not justify the need for the establishment of a school of optometry in the State of Florida, and

Whereas, the tremendous expenditure of public funds that would be required can better be used for other educational purposes, therefore, be it

RESOLVED, that the Florida Medical Association opposes the establishment of a school of optometry in the State of Florida.

2. That the Florida Medical Association requests that the component medical societies in Florida be apprised of any impending health screening and given the opportunity to advise and participate in such screening in the interest of providing the best possible quality medical care.

## Report of Board of Governors

### Board Action No. 4 Community Health Education Act

The Reference Committee recommended that Board Action No. 4 be adopted as presented.

It was adopted.

(See Report of Board of Governors, page 51)

### Board Action No. 14 Current Changes in Medical Education

The Reference Committee recommended that Board Action No. 14 be adopted as presented.

It was adopted.

(See Report of Board of Governors, page 51)

### Board Action No. 17 and

### Board Recommendation No. 7 Florida Regional Medical Program

The Reference Committee recommended that Board Action No. 17 be adopted. It was adopted.

(See Report of Board of Governors, page 52)



The Reference Committee recommended that Board Recommendation No. 7 not be adopted.

A motion was made from the floor to amend Recommendation No. 7. The motion carried, and Recommendation No. 7 was adopted as amended. (See Report of Board of Governors, page 52)

### Board Action No. 18 and Recommendation No. 10

#### Statewide Health Education Conference

The Reference Committee recommended that Board Action No. 18 and Recommendation No. 10 be adopted.

They were adopted.

(See Report of Board of Governors, page 52)

### Committee on Drug Abuse

The Reference Committee recommended the adoption of the report of the Committee on Drug Abuse and its recommendation.

They were adopted.

## Committee on Drug Abuse

DANIEL SECKINGER, M.D., *Chairman*

The Committee on Drug Abuse held seven meetings during the period of this report. Another meeting is scheduled May 2, 1973. At these meetings, which were held throughout the state, a variety of subjects was considered.

The drug abuse problem is many-faceted, thus involving diversified disciplines. This diversity is reflected in the committee's membership, which includes not only physicians in several specialties, but educators, lawyers, judges, law enforcement officials, pharmacists, clergymen and others. In its short existence of slightly over two years, the committee, after educating itself to the problem, has had to attack it on a number of fronts. While it is encouraging to report that considerable progress has been made in some areas, much yet remains to be done. The committee currently has a special subcommittee assessing this progress and developing recommendations for future goals.

The following brief summary of some of the committee's activities by subject area will illustrate the variety of tasks undertaken. This annual report will be concluded with recommendations.

**Marijuana**—One of the most perplexing and least understood drug abuse problems is the use and effects of marijuana. During its entire existence, the committee has struggled with developing a policy on this subject. In late 1972, after careful research and study of all available information, a subcommittee presented a report which resulted in formulation of a policy statement on the use of marijuana. This policy statement is the committee's major recommendation in this report.

**Involvement of medical profession**—The committee has devoted considerable effort to informing and involving the medical profession in drug abuse-related activities. The "Physician's Desk Reference on Drug Abuse," which

the committee developed and distributed to all Association members early in 1972, has been well received and numerous requests for additional copies have been filled. This publication is in need of early revision. The placard entitled "To My Patients," which encourages patients to discuss drug problems with physicians, has been furnished to hundreds of interested doctors for display in their offices. Articles on various aspects of the drug problem have been prepared by members of the committee and published in the *Journal of the Florida Medical Association*. A panel discussion on the medical aspects of marijuana will be presented as part of the Association's 1973 annual meeting program. Finally, the committee has attempted to encourage and assist county medical societies in establishing active drug abuse committees. The chairmen of such committees have been invited and have attended and participated in meetings of the state committee in each local area where it has met.

**Liaison with state agencies**—The committee has continued to serve in an unofficial advisory capacity to state agencies with responsibilities in the drug abuse area, including the Department of Health and Rehabilitative Services and its various divisions and programs, the Department of Education, the Department of Law Enforcement, the Office of the Attorney General and others. Special efforts have been made to keep abreast of the many activities and plans of the Drug Abuse Program of the Department of Health and Rehabilitative Services. With the impending federally-required creation of an advisory council to the latter agency, the committee is carefully analyzing its future role in relation to the new official body.

**Drug abuse spending**—During the period of this report, the committee has been greatly concerned with evaluation of drug abuse spending in Florida, which originates from a variety of federal, state and local sources. Special attention has been given to the funding problems of local drug abuse education, treatment and rehabilitation programs. To help set state priorities in this area of importance to all taxpayers is one of the committee's continuing objectives.

**Legislation**—Another continuing activity of the committee has been to provide consultation, advice and review of proposed state drug-related legislative measures. A state capital-based subcommittee functions for this purpose. This subcommittee maintains close liaison with the Association's Committee on State Legislation and Capital Office.

**Liaison with judiciary**—To determine the needs and attitudes of judges with jurisdiction over juvenile and drug abuse matters, the committee initiated and participated in two surveys of members of the judiciary in Florida. The survey results were of value to several agencies with related responsibilities and, through joint effort by two of its subcommittees, followup efforts are being made to assure that the survey findings are of effective assistance to the judges.

**Division of Youth Services**—Through its early concern with the handling of youthful drug offenders in state facilities operated by the Division of Youth Services, the committee has directly and indirectly brought about interest in many of the problems of this state agency. During 1972, the Division, in cooperation with the HRS Drug Abuse Program and the Department of Education, established an in-service drug abuse training program for counselors in child training schools. The committee's representative from the Woman's Auxiliary to the Association has been appointed by the Division as an "ombudsman" for the youth and staff of all its facilities and she has personally visited nearly all of them throughout the state. She also has been appointed to a special committee studying the entire problem of youth detention in the state. Finally, through the long efforts of the committee and one of its subcommittees, the Division is planning a state group treatment center for youthful drug abusers.

**Testing for dangerous drugs**—During the past year, the committee has been instrumental in the needed expansion of urine screening services for dangerous drugs,

particularly by the laboratories of the Division of Health, to assure uniform availability and quality control of these services to such organizations as methadone maintenance programs.

**Heroin addiction and methadone maintenance**—The committee has been concerned with the need for a state center for detoxification of heroin addicts and such a facility is now in the planning stage. The committee also has kept itself informed of new federal and state regulations for the operation of methadone maintenance programs.

**School guidelines**—The committee has attempted to encourage wide utilization of its guidelines for teachers and other education personnel for dealing with drug problems in the schools.

**College health**—Assistance was furnished to the Association's Committee on College Health in the solution of drug-related problems of college and university health services.

**Future goals of committee**—As indicated earlier, the committee is engaged in evaluating its past and present functions and activities in order to develop objectives and priorities for its future efforts. It is the committee's opinion that such periodic reappraisal is essential in this rapidly-changing field.

## RECOMMENDATION

That the following policy statement be adopted and disseminated as widely as possible:

"After reviewing the literature currently available on marijuana use and its effect on physical and mental health, the Florida Medical Association finds no evidence that the use of this drug serves any beneficial purpose. Although research is as yet inconclusive, the use of marijuana may be injurious to the individual's health. Therefore, the Florida Medical Association goes on record as opposing the use of this drug in any form."

### Resolution 73-26

#### Proposed Mandatory Sickle Cell Screening

##### Duval County Medical Society

The Reference Committee recommended deletion of the words "of pre-parents," and the substitution of the words, "sickle cell disease or trait," for the word "involvement," in the second "Resolved." The amendments were adopted, and the last two "resolves" were adopted as amended.

The first "resolve" was adopted by Reference Committee No. IV later in the meeting (see page 74 for action); therefore, Resolution 73-26 was adopted as amended.

### Resolution 73-26

#### Proposed Mandatory Sickle Cell Screening

RESOLVED, That the FMA oppose the mandatory (permissive exclusion disguised as voluntary participation) screening and reporting provisions of the Cherry-Hazleton-Hodes bill #CB/HB 71+106: A Sickle Cell Disease Act, be it further (Adopted—R.C. IV)

RESOLVED, That the FMA encourage the voluntary screening and counseling of high school and college aged individuals with increased risk of sickle cell disease or trait, be it further

RESOLVED, That the FMA encourage the adoption of the recommendations from the Sickle Cell Anemia Seminar held at the Florida Division of Health, Jacksonville, October, 1972.

### Resolution 73-28

#### Anti-Smoking Education Program

##### Volusia County Medical Society

The Reference Committee recommended the adoption of a substitute resolution for Resolution 73-28, to be called Substitute Resolution 73-28, Anti-Smoking Education Program.

Substitute Resolution 73-28 was adopted.

### Substitute Resolution 73-28

#### Anti-Smoking Education Program

RESOLVED, That the Florida Medical Association urge the proper authorities to instigate a vigorous anti-smoking program in the schools and discourage smoking by all possible means.

Dr. Straight: "Mr. Speaker, your chairman wishes to thank the members of Reference Committee No. 1: John T. Blackburn, M.D., Paul C. Harding, M.D., Thomas M. McKell, M.D., F. Norman Vickers, M.D., FMA staff members Gordon H. Hubbard Jr., and Sharyn J. Dennis and the members of the Association who appeared before us for their valuable contributions to the deliberations of the reference committee and their efforts in the preparation of this report."

Motion carried to adopt the report of Reference Committee I as a whole as amended.

Dr. Straight: "Mr. Speaker, this concludes the report of Reference Committee No. I."

A motion was made to take Board Action No. 30 (Reference Committee No. V) out of order and consider it at this time.

The motion failed to carry.



# Report of Reference Committee No. II

## Public Policy

The Vice Speaker, Dr. Murray, assumed the Chair and called for the report of Reference Committee No. II.

Dr. Charles F. Tate Jr., Chairman, presented the report of Reference Committee No. II, Public Policy.

### Council on Allied Professions and Vocations

The Reference Committee recommended that "90 days" in the last paragraph of the Committee on Physical Therapy and Rehabilitation be amended to read "30 days."

The amendment was adopted.

The Reference Committee recommended that Recommendation 1 be amended by deleting the words, "to make this determination," and substituting the words, "to make determinations of blood sugar and drugs (barbiturates and alcohol)."

There was discussion, and the amendment was adopted.

A motion was made from the floor to further amend Recommendation 1 to add the words, "at designated places."

This amendment was adopted.

The Reference Committee recommended that the word "and" be deleted from Recommendation 4 where it appears following the second semicolon and the following be added at the end of the sentence: "and that the philosophy be made explicitly clear that the nurse, in all of her activities

in taking care of the patient, remains directly responsible to the physician."

The Reference Committee also recommended that the word "authority" be deleted from Recommendation 5.

A substitute motion was made from the floor that Recommendations 4, 5, and 6 be referred to the Board of Governors for an indepth investigation and report back to this House. There was discussion.

The substitute motion to refer carried, and Recommendations 4, 5 and 6 were referred to the Board of Governors.

The Reference Committee concurred with the recommendation of the Board of Governors, and recommended that Recommendation 12 of the Council not be adopted.

Recommendation 12 was not adopted.

The report of the Council on Allied Professions and Vocations was adopted as amended.

### Council on Allied Professions and Vocations

JAMES J. DEVITO, M.D., *Chairman*

The Council on Allied Professions and Vocations held two meetings during the year, September 10, 1972, and February 25, 1973. The following is a summary of the activities and recommendations of the 13 committees under the Council.



Charles F. Tate Jr., M.D., Miami (standing) was Chairman of Reference Committee II. His Committee included (left to right): Edward W. Stoner, M.D., Oviedo; Robert N. Webster, M.D., Tallahassee; Andre S. Capi, M.D., Pompano Beach and Roger A. Laughlin, M.D., St. Petersburg. Mrs. Sandy Neel served as secretary to the Committee.



**Committee on Law**—Joseph H. Davis, M.D. has been added to the committee so that now the committee is composed of two members. One informal meeting was held during the year to discuss the implied consent law. The committee plans to meet with the Florida Bar sometime in the near future.

**Committee on Medicine and Religion**—The committee held two meetings during the year, October 1, 1972, and February 18, 1973.

The committee is sponsoring the first Annual President's Prayer Breakfast at the FMA Annual Meeting this year. The committee hopes to have a very interesting program to make the Prayer Breakfast an immediate success and hopefully a part of the Annual Meeting each year.

The chairman and FMA staff to the committee attended the AMA Regional Workshop in Atlanta on February 10, 1973.

The chairman presented a program on Medicine and Religion to the Nassau County Medical Society. The committee hopes to encourage and assist more county societies in the coming year in communicating to the physicians of Florida the Medicine and Religion theme "The Whole Man."

Since the committee is also to serve as a liaison between physicians and clergymen, the committee is recommending three hospital chaplains to serve as advisory to the committee.

The committee is also sponsoring one of the AMA Medicine and Religion exhibits at the FMA Annual Meeting this year.

Long range plans of the committee include holding a seminar in conjunction with one of the state's medical schools on a major theme of interest to physicians today.

**Committee on Nursing**—The committee had a very active year holding four meetings on September 9, 1972, December 10, 1972, February 11, 1973, and April 29, 1973.

On the national level, the National Joint Practice Commission has been formed as a cooperative effort between the American Medical Association and the American Nurses Association. This Commission has urged all states to set up a State Commission which encouraged this committee to merge with the FNA Medical Liaison Committee to serve as the State Commission. The committee and the FNA Medical Liaison Committee have proposed a merger of the two respective committees to be co-chaired by the chairman of each existing liaison committee.

The committee has formulated objectives and criteria for joint position statements for the joint committee, and there continues to be a productive exchange of information at each meeting and enhanced mutual understanding between the two professions.

**Committee on Opticians**—The committee held no formal meetings during the year. However, the committee has been in frequent communication with the opticians both through the Florida Association of Dispensing Opticians and through the Florida Board of Opticians.

At the present, there are no problems and they are progressing well with their program of continuing education.

**Committee on Physician's Assistants and Medical Assistants**—The committee met once during the year, February 24, 1973. The committee plans to compile, with the aid of the Physician's Assistants Program at the University of Florida, a master list of physicians interested in employing a physician's assistant and physician's assistants interested in employment in Florida.

Stage two approval was recommended for the Santa Fe Community College—University of Florida Physician's Assistants Program.

The committee studied a request from the American Academy of Physician's Assistants for affiliation with the Florida Medical Association. It was pointed out that there are two such national groups, the American Academy of Physician's Assistants and the American College of Physician's Assistants. The AMA has suggested a

merger of the two groups. The committee decided to wait until the merger and formal state chapters were set up before setting up any affiliation.

The committee also requested that Mr. David Lewis, Associate Director of Physician's Assistants Program at the University of Florida, be retained as an advisory to the committee.

**Committee on Physical Therapy and Rehabilitation**—The committee met once during the year, June 3, 1972. This was a joint meeting with the Florida Chapter of the American Physical Therapy Association and Florida Occupational Therapy Association.

The committee once again discussed the Blue Shield arbitrary limitation of physical therapy under Medicare. Following discussion of possible methods of utilization control, it was determined that the entire question should be referred to the Committee on Advisory to Blue Shield and Fiscal Intermediaries.

Considerable time was given to consideration of the use of check off prescriptions by many physical therapists in the State of Florida. Abuses of such prescriptions, constituting violation of the physical therapy law, are and have been frequent. This practice, in effect, amounts to the practice of medicine by physical therapists.

Following discussion with physical therapists concerning the practice of Workmen's Compensation medicine and physical therapy, the committee is recommending to the Florida Department of Commerce that all cases receiving physical therapy require a physician's written prescription at least every 30 days.

**Committee on Podiatry**—The committee met once during the year, February 17, 1973. This was a joint meeting with members of the Florida Podiatry Association.

Several issues were discussed at the meeting including podiatrists performing surgery, educational requirements for a podiatrist, licensing requirements, podiatrists' fees, and the possibility of podiatrists being able to attend continuing medical education programs for M.D.'s in the State. A channel of communication has been opened with the podiatrists, and the committee would like the Association to keep this communication open through this committee.

**Committee on Radiologic and Nuclear Medicine Technologists**—The committee held no formal meeting during the year. However, the committee is staying abreast of attempts to make licensure of radiologic and nuclear medicine technologists a requirement and is helping to oppose this.

**Committee on Veterinary Medicine**—No formal meeting of the committee was held. However, the chairman did meet with several veterinarians to discuss issues that may involve physicians. Items discussed were the ease with which any person could buy veterinary drugs, thus adding to the drug abuse problem, the fact that the veterinarians would like representation on the State Board of Health, and the veterinarians would like to develop better liaison with the state legislature with the help of the Florida Medical Association.

An open line of communication has been formed, and the committee hopes to maintain close contact with the veterinarians.

There were no reports of major activity received from the Committees on Dietetics, Dentistry, Medical Technologists or Pharmacy.

## RECOMMENDATIONS

### (Committee on Law)

1. That under the Implied Consent Law, if a peace officer suspects a person of being intoxicated, that it be made mandatory for blood to be drawn to make determinations of blood sugar and drugs (barbiturates and alcohol) at designated places.
2. That if a peace officer is present at the time blood is drawn, his witness of this

act shall be sufficient evidence so that the physician will not be subpoenaed merely for the purpose of identifying the blood.

(Committee on Medicine and Religion)

3. That the committee write each county medical society advising them of the committee and its functions and informing them that a number of brochures and films are accessible and available upon request.

4. [REFERRED TO BOARD OF GOVERNORS]

(Committee on Nursing)

That there be established a joint practice committee on medicine and nursing; that this committee be called the Joint Practice Committee of Medicine and Nursing; and that this committee represent the Florida Medical Association and Florida Nurses Association, and take the place of the current liaison committee from each organization.

5. [REFERRED TO BOARD OF GOVERNORS]

That the following objectives of the Joint Practice Committee of Medicine and Nursing be approved:

- (1) Examine the authority, responsibility, and operation of each profession in terms of current and projected practice patterns.
- (2) Identify social, educational and economic barriers which now prevent or impede quality health care.
- (3) Outline the methods and procedures for the establishment of local joint practice committees.

6. [REFERRED TO BOARD OF GOVERNORS]

That the criteria for joint position statements on practice be approved:

"Over the years, as physicians and nurses have worked together caring for patients, activities in the spectrum of health care have multiplied. This has demanded a reconsideration of the preparation of the physician and nurse as well as a change in their functions. In addition, rapid advances in scientific knowledge and technology, consumer demands, availability of health personnel, and innovations in professional education have magnified the need for adjustments. Realizing this, the Joint Practice Committee of Medicine and Nursing submits the following criteria for joint position statements on practice.

"The Florida Medical Association and the Florida Nurses Association recognize the two distinct, yet complementary, roles and responsibilities of the physician and nurse in the delivery of health services to the

citizens of Florida. There have been, and will continue to be, shifts and adjustments in these roles and responsibilities.

"In order that our citizens may receive the best possible medical and nursing care, it is essential that physicians and nurses at all levels, state, city, county and individual agency, plan together for delivery of these health services. Mutually developed written protocol will help to clarify responsibilities and should result in improved health care of individuals and families.

"The FMA and FNA feel it is of extreme importance to include the following criteria when delegating functions to nurses:

- (1) That it is safe for, and in the best interest of the patient.
- (2) That the nurse has been adequately taught this function, been judged to be competent feels competent in performing this function, and written evidence of capability is available.
- (3) That there is mutually developed written protocol governing the delegated functions, and medical consultation is available.

"Although this statement is concerned only with physicians and nurses, we recognize the need for all health professionals concerned with health care of people to plan together for the delivery of health services in all health care institutions and to provide for continuing education for all health workers. We also recognize that it is the responsibility of each individual practitioner to maintain and improve his/her proficiency in practice."

(Committee on Physician's Assistants and Medical Assts.)

7. That the Florida Medical Association encourage the setting up of state chapters of the American Academy of Physician's Assistants with a designated official spokesman for the state chapters.
8. That the Florida Medical Association suggest to county medical societies that it is reasonable to invite physician's assistants, certified by the Florida State Board of Medical Examiners, to participate in program of continuing medical education and/or county medical society meetings.
9. That Stage 3 Approval (full endorsement) be given to the Cardiovascular Tech-



nician Training Program at the University of Florida, pending further clarification of its conformance to the seven criteria used in reviewing all new programs.

10. That Stage 3 Approval (full endorsement) be given to the program of utilization of closely supervised physician's assistants in Gilchrist County as presently outlined and operated by M.D. Directors of the Santa Fe Community College — University of Florida Physician's Assistants Training Program.
11. That Stage 2 Approval be given to the Associate Degree Program for Physician's Assistants at Santa Fe Community College — University of Florida College of Medicine.
12. [NOT ADOPTED]
13. That the Committee on Podiatry of the Florida Medical Association should continue to meet with and communicate freely with the equivalent committee of the Florida Podiatry Association.

#### Council on Medical Services

On Recommendation No. 17 of the Council on Medical Services, the Reference Committee concurred with the Board of Governors and recommended that the phrase "or county health departments" be deleted.

The recommendation was adopted.

The Reference Committee recommended that in Recommendation 21 the word "a" be inserted after the word "seek" and that the word "legislation" be deleted, substituting the word "standard."

The recommendation was adopted.

The report of the Council on Medical Services was adopted as amended.

#### Council on Medical Services

THOMAS B. THAMES, M.D., *Chairman*

During the period of this report, a majority of the Council's 13 committees showed considerable activity. With the abolishment in 1972 of the Committee on Labor, the Council now has one less committee but still remains a large and diversified portion of the Association's organization. Several of the committees met frequently and most provide medical advice in their areas of competence throughout the year to governmental agencies, legislative committees and various organizations. Many of their recommendations and activities are reflected in reports and actions of other bodies such as the Board of Governors, the Committee on State Legislation, the Florida Department of Health and Rehabilitative Services and the Florida Department of Education.

In the reporting period, the Council held one formal meeting on February 25, 1973 to act upon pending

matters of concern to the entire Council, to consider annual reports and recommendations from the individual committees, and to adopt those recommendations to be included in the Council's annual report. The following report will begin with short summaries of major matters affecting the entire Council or more than one of its committees and will be followed by brief descriptions of the primary activities of each committee. The report will be concluded with the Council's recommendations for 1972-73.

**Legislative Advice**—In preparation for the 1973 session of the Florida Legislature, the Council and its committees assisted the Committee on State Legislation in reviewing a large number of prefiled bills of medical interest. Suggestions were made for an appropriate Association position on each measure. During the session and at all other times, the expertise of the various committees was made available for consultation on legislative matters.

**National Health Service Corps**—The Council continued to monitor the activities of this unique federal program designed to place physicians, dentists, nurses and other health personnel in critical areas of need throughout the nation. As of this report, there are six physicians, four dentists and one nurse on duty in five approved Florida locations. These locations are Belle Glade (Palm Beach County), Cross City (Dixie County), Frostproof (Polk County), Immokalee (Collier County) and Lake Butler (Union County). The Council has been given responsibility for reviewing community applications for personnel and recommending appropriate Association action on each. The Council is also keeping abreast of the new "Project USA" program under which the American Medical Association supplies physicians for short-term assignments to relieve National Health Service Corps personnel.

**Retirement communities**—The Council and several of its committees have been concerned with the health and medical needs of residents of remotely-located retirement communities in the state. This complicated problem is perpetuated by some real estate developers who construct subdivisions in rural outlying areas without regard to the medical needs of their new inhabitants, most of whom are unfamiliar with this situation at the time they purchase their properties. Following a 1972 Council recommendation on this subject, the Board of Governors adopted a policy statement which the Council endorses.

**Medical care delivery in underserved areas**—The broad problem of delivery of medical care in underserved areas and to underprivileged population groups has been given considerable attention by the Council. A new Subcommittee on Health Care of the Poor, which is in the process of being activated, has been given this assignment and it is anticipated that some innovative approaches to this serious problem will be developed.

**Health screening of indigent children**—The problem of providing health screening and physical examinations to indigent and near-indigent children has been of concern to the Council, especially in view of recently-adopted state requirements for school admission. Some recommendations were developed regarding the funding of programs to provide these services.

**Resolution 72-2**—The Council considered Resolution 72-2, "Cardiopulmonary Resuscitation Training for Ambulance Personnel," which had been adopted by the House of Delegates in 1972 and referred by the Board of Governors to the Council for implementation. It was the Council's opinion that no action was necessary in that the intent of the resolution is fulfilled by legislation being introduced in the 1973 session of the Florida Legislature which is backed by numerous organizations and agencies.

**Plasmapheresis**—The Council continued to be concerned with the problem of inadequate regulation of plasmapheresis centers. With knowledge of a possible assumption of such regulatory responsibility by the federal government, the Council authorized the Committee on Blood to develop recommendations for state regulation if this jurisdiction is not assumed at the federal level.



**Liaison with H.R.S.**—During the past year, the Council noted an increased and improved liaison between the Association and the Florida Department of Health and Rehabilitative Services due to the efforts on the part of both parties to bring about understanding and cooperation between the private and public sectors of medicine. One mechanism for achieving this purpose was a well-attended medical and dental conference held in the fall of 1972 sponsored by the Department in conjunction with the Association and other professional groups. The conference afforded medical leaders and state officials an opportunity for mutual discussion of the state's medical service programs and problems. A second such conference is planned for the fall of 1973.

**Committees:**

The Committee on Aging maintained liaison with the various groups and official agencies interested in the problems of older citizens. It has continued to represent the Association on the 10-member Florida Joint Council on Health of the Aging; the committee's chairman was elected chairman of the Joint Council for 1973. In view of a recent reorganization of the Florida Council on Aging, the major state organization concerned with all aspects of gerontology, which is expected to result in more effective participation by the health professions, consideration is being given to dissolving the Joint Council as a duplication of effort.

The Committee on Blood kept abreast of all developments in the blood field. It continued attempts to bring about more effective regulation of plasmapheresis centers and maintained liaison with blood banks.

The Committee on Child Health met quarterly as School Health Medical Advisory Committee to the Department of Education and Division of Health, Department of Health and Rehabilitative Services of Florida. In this capacity, the committee considers and acts upon a large variety of matters affecting the health of the state's children and youth. A major accomplishment during the past year was the adoption and distribution of guidelines or minimum standards for the purchase of accident insurance by the county school systems. Among other subjects considered and acted upon by the committee were tuberculin testing of school personnel, health education legislation, fluoride content in infant ready-to-use formulas, Medicaid screening for children, new vision screening standards for schools, PKU testing, mouth-to-mouth resuscitation training in schools, and teaching high school girls the importance of cytology smears of the genital tract and self-examination of the breast.

The Committee on College Health expended its primary effort in problems relating to the funding of university health services and the privilege of legal confidentiality for university physicians, particularly in drug abuse and family planning counseling and services. The committee continued to maintain liaison with physicians responsible for student health services in public and private colleges and universities.

The Committee on Emergency Medical Service remained abreast of developments in the rapidly changing field of emergency medicine. Members of the committee serve on the state emergency medical service advisory council to the Division of Health. The chairman is a member of the American Medical Association's Committee on Community Emergency Services. The committee has concerned itself with the regionalization of emergency services and with the development of comprehensive legislation in this field.

The Committee on Hearing concerned itself with hearing screening programs in the schools and provided consultation and advice in this area.

The Committee on Maternal Health continued the statewide maternal mortality study it has conducted for a number of years. It served in an active advisory capacity in the development of rules and regulations for Florida's revised abortion statute of 1972. Following the recent invalidation of most state abortion laws by the Supreme Court, and evaluation of its effect upon the practice of medicine, the committee is considering the development of medical and ethical abortion guidelines for physicians.

The Committee on Mental Health concerned itself with problems relating to implementation of the Florida Mental Health Act (the "Baker Act") which became effective July 1, 1972, and worked closely with the Florida Psychiatric Society in developing needed amendments to this far-reaching legislation. The committee also provided consultation in developing regulations for Florida's 1972 abortion law and has under study the effects of the recent Supreme Court ruling on this subject.

The Committee on Mental Retardation has attempted to build a foundation for a comprehensive program in its field by identifying and involving interested and knowledgeable members of the medical profession and other disciplines, establishing guidelines for state programs, developing acceptable standards for medical components, and establishing liaison with state and local agencies concerned with the broad area of developmental problems in childhood. Particular emphasis has been placed during the past year upon maintaining close liaison with state officials heading major programs related to retardation. In all of its endeavors, the committee has worked closely with the Florida Pediatric Society.

The Committee on Occupational Health has kept abreast of developments in the area of industrial and occupational medicine and maintained liaison with other professional groups such as the Industrial Medical Association and the Florida Society of Preventive Medicine.

The Committee on Public Health and the Environment continued to be one of the Council's most active committees in dealing with numerous matters in its broad scope. Among subjects considered and acted upon were the distribution and implementation of recommendations of the 1972 Florida Communicable Diseases Conference, the long-term effects of pesticides upon humans, health services in remotely-located retirement communities, the organization of state health and environmental services, laboratory screening services for dangerous drugs, prenatal testing and laboratory services for gonococcus, medical services in correctional facilities, funding for the statewide medical examiners system, animal bites in children, the need for a school of public health in Florida, and many others.

The Committee on Rural Health, as it has for the past 17 years, continued to represent the Association and provide leadership in the Florida Committee on Rural Health, a joint coordinating and planning group in which seven leading state agricultural and health organizations and agencies participate. Members of the FMA committee serve on the various subcommittees of the joint group, working to improve health conditions and services in the state's rural areas. During the past year, emphasis has been placed upon problems relating to safety and emergency services.

The Committee on Vision, in consultation with major groups concerned with eye and vision problems, developed revised vision screening standards for the state's schools which are being placed in effect.

## RECOMMENDATIONS

1. That the Association actively support the Florida Council on Aging by (A) becoming an organizational member, thereby gaining a voting seat on its board of organizations, and (B) encouraging physicians to become individual members with active participation in the council's new section on health.
2. That authorization be given to discontinuing the Florida Joint Council on Health of the Aging as a duplication of effort or, if a majority of the other member organizations elect to retain the group, permission be granted for withdrawal of the Association.

3. That the Association encourage innovative programs of health care for the aged and thorough evaluation of those in existence.
4. That the Association through its Council on Scientific Activities promote increased and improved utilization in medical education of study of the problems of aging.
5. That the funding of programs to provide physical examinations and screening for indigent and near-indigent children be given priority in the Association's legislative program. (amended R.C. IV)
6. That mouth-to-mouth resuscitation be taught in the schools as part of first aid instruction.
7. That the need be recognized for teaching high school girls the importance of Papanicolaou smears and the techniques for self-examination of the breast and that in-service teacher education in these subjects be initiated in cooperation with the Florida Division, American Cancer Society, with the involvement of public health nurses.
8. That privileged and confidential information regarding medical matters in a student's school records not be released without the permission of the student and the parents.
9. That all laboratories performing testing for phenylketonuria (PKU) and other metabolic diseases participate in a quality control program in which tests are performed periodically on specimens approved by the Bureau of Laboratories, Division of Health, Department of Health and Rehabilitative Services, and that all proven diagnosed cases be reported to the Division of Health for follow-up appropriate treatment and management as required by law.
10. In view of the importance of achieving and maintaining sound health as a basis for the learning process, that adequate health services be made available to the students in all public and private universities in Florida, and that such services be funded in such a manner as to assure adequate health care for students and clear identification of health service fees separate from other fees and charges.
11. [NOT ADOPTED—R.C. IV]
12. That the following policy statement on environmental health be adopted: "The Association reaffirms its position that the health of all people is directly affected by environmental factors. Although many governmental agencies have environmental protection duties, the state agency responsible for human health should have final authority to monitor, advise or otherwise act as necessary to protect human health. It is the Association's further position that relationships between the state agency and county health departments are extremely important and should be continued and expanded."
13. That prenatal testing for gonococcus be encouraged wherever feasible, but any state legislation requiring mandatory universal testing be opposed. (R.C. IV)
14. [REFERRED TO THE BOARD OF GOVERNORS] That high priority in the Association's 1973 legislative program be placed upon adequate funding of Florida's Statewide Medical Examiners System. (Referred to Board of Governors—R.C. IV)
15. That adequate funding for the state renal disease program be endorsed, but that this program be assigned administratively to the Bureau of Adult Health and Chronic Diseases of the Division of Health rather than being established as a categorical separate bureau. (R.C. IV)
16. That the Association recommend and support the establishment of a school of public health in Florida with a broad curriculum to include the many diversified areas of interest and need in this field.
17. That the 1972 policy statement of the Board of Governors regarding the health and medical needs of residential retirement communities be reaffirmed with the additional suggestion that arrangements be made with nearby practicing physicians to have physicians and/or nurses available in such communities at all times or on certain days of the week.
18. That state and county road or transportation departments construct, wherever feasible, bicycle paths parallel to, but at a safe distance from, all state and county roads.
19. In order to provide medical students insight into the advantages and satisfaction of rural medicine, that medical schools be encouraged to arrange for medical students to spend some time working with rural physicians.
20. That greater efforts be undertaken through school health education programs, the Cooperative Extension Service and other agencies to provide medical self-help and first aid courses in rural communities, with a goal of having at least one member of every family so trained.
21. That the Association request its delegates to the American Medical Association to seek a federal standard requiring the automobile industry to place front and rear bumpers on trucks low enough to prevent decapitation accidents to automobile passengers.
22. That the Association seek stringent enforcement of a regulation that all slow-moving vehicles on the highways display



a standard red triangle warning sign on the rear of such vehicles.

### Council on Voluntary Health Agencies

The Reference Committee recommended that the report of the Council on Voluntary Health Agencies be adopted as printed.

It was adopted.

## Council on Voluntary Health Agencies

ROBERT E. WINDOM, M.D., *Chairman*

Your Council on Voluntary Health Agencies has met twice during the Association year now ending—on October 1, 1972, and on February 17, 1973. At both meetings we had productive conferences with the executive directors of voluntary health agencies recognized by the Florida Medical Association. We are pleased to present this report of our activities.

...Recognition for 1973-74: Your Council gave careful study to applications submitted by several voluntary health agencies for official recognition by the Florida Medical Association. Each application was considered in the light of our 12 criteria for recognition. On this basis, we were pleased to recommend to the Board of Governors that the following agencies be recognized for 1973-74:

Florida Division, American Cancer Society  
Florida Chapter, The Arthritis Foundation  
Easter Seal Society for Crippled Children and Adults of Florida, Inc.

Florida Association for Retarded Children  
Florida Heart Association, Inc.  
Florida Kidney Foundation, Inc.  
Florida Society for the Prevention of Blindness, Inc.  
Florida Tuberculosis and Respiratory Disease Association

Florida Division, Leukemia Society of America  
Mental Health Association of Florida, Inc.  
National Multiple Sclerosis Society  
The National Foundation—March of Dimes  
United Cerebral Palsy of Florida  
Florida Epilepsy Foundation, Inc.

The Council welcomes to the family of FMA-recognized agencies the Florida Epilepsy Foundation, Inc., which was recognized for the first time.

Recognition Procedures: This year, for the first time, the Council developed and used a two-page form on which each agency reported the information necessary to evaluate the agency. This form facilitated the evaluation process markedly and will be used in the future with possible refinements.

The Council will continue to issue recognition certificates to recognized agencies, a practice that began last year. However, the certificate is being redesigned to make it more suitable for framing and display. Each agency will be supplied with a sufficient number of certificates so that they can be displayed in all their Florida offices.

This year, the Council received an application for recognition from a county-based agency. The application was turned down because (1) the agency had not been in operation long enough to allow for proper evaluation, and (2) it has been the practice of the Council to recognize organizations which serve the entire state. In view of this, the Council has recommended to the Board of Governors that the following criterion be added to the existing guidelines:

"Must have a service area including the entire state of Florida or a substantial geographical area or population segment therein."

AMA Council on Voluntary Health Agencies: Your Council regrets that the Board of Trustees of the American Medical Association found it necessary to abolish the AMA Council on Voluntary Health Agencies. Your Council believes it is extremely important for organized medicine to maintain effective communication and liaison with the voluntary health movement. Believing that strong liaison at the state level is now more important than ever before, your Council submitted the following statement to the Board of Governors:

"Whereas, the Council on Voluntary Health Agencies of the Florida Medical Association has evolved as a catalyst for voluntary health agencies to work together for the common good, and because it is believed that the Council has assisted them in being more effective, particularly as they have related to Florida medicine and the general public; and

Whereas, the Council on Voluntary Health Agencies finds that the American Medical Association's action terminating the AMA Council on Voluntary Health Agencies is regrettable;

Therefore, the Council on Voluntary Health Agencies of the Florida Medical Association recommends to the FMA Board of Governors that it continue to support this Council and its close relationship with voluntary health agencies in the State of Florida."

Ad Hoc Committee to Appraise the Florida Regional Medical Program: The Executive Committee referred to this Council Recommendation #2 (1972) of the Ad Hoc Committee to Appraise the Florida Regional Medical Programs. This recommendation stated: "That appropriate safeguards be developed and maintained to avoid duplication of effort between FRMP and the FMA, state and voluntary health agencies, and educational institutions." This Council has reported back to the Executive Committee and Board of Governors recommending that Recommendation #2 be dropped from further consideration in view of the apparent phasing out of the Regional Medical Programs.

CMS/VHA Liaison: Your Council believes that the voluntary health movement has made and will continue to make significant contributions to medical science through assistance in patient care, education and research. For this reason, the Council would like to see more physicians become actively involved in the agencies of their choice.

The Council believes it is providing good liaison at the state level with voluntary health agencies. More involvement is needed at the county level. Therefore, it has been recommended to the Board of Governors that county medical societies be encouraged to establish liaison committees with voluntary health agencies. It should be emphasized that physicians selected for these assignments should have a definite interest in working with voluntary health agencies.

Woman's Auxiliary to the Florida Medical Association: Officers of the Woman's Auxiliary to the Florida Medical Association have indicated they have a definite interest in the work of this Council. The Auxiliary wants to appoint one of its members to sit with this Council in a non-voting, advisory capacity. Your Council concurs in this proposal and has made the appropriate recommendation to the Board of Governors.

Educational Exhibit: The Florida Voluntary Health Association is sponsoring again this year an educational exhibit at the FMA Annual Meeting. The FVHA has the support of the Council in this regard, and we would urge all Delegates to visit this exhibit.

Journal Article: In the hope of stirring up more interest on the part of FMA members in the work of voluntary health agencies, this Council will this year submit a manuscript for publication in *The Journal of the Florida Medical Association*. It is envisioned that this article will describe the program of the Council on Voluntary Health Agencies and give a brief description of the programs and objectives of each of the FMA-recognized agencies.



## RECOMMENDATIONS

1. That county medical societies be encouraged to establish local committees on voluntary health agencies; and that the component societies seek out physicians with special interest in the voluntary health movement for these assignments.

### Report of Board of Governors

(Referred by 1972 House of Delegates)  
Health & Medical Needs, Retirement  
Residential Communities

The Reference Committee considered the Board of Governors' Report on the item referred to it by the 1972 House of Delegates—Health and Medical Needs, Retirement Residential Communities and recommended that it be adopted as presented.

It was adopted.

(See Board of Governors Report, page 49)

#### Resolution 73-6

Cardio-Pulmonary Resuscitation in High Schools  
Duval County Medical Society

The Reference Committee recommended that Resolution 73-6, Cardio-Pulmonary Resuscitation in High Schools, be adopted as presented.

Resolution 73-6 was adopted.

#### Resolution 73-6

Cardio-Pulmonary Resuscitation in High Schools

RESOLVED, That the Florida Medical Association endorses the Department of Public Safety program for Cardio-Pulmonary Resuscitation in the high schools of Florida supervised by expert instructors under the direct supervision of licensed physicians.

#### Resolution 73-27

Food and Drug Administration

Polk County Medical Association

The Reference Committee recommended that Resolution 73-27, Food and Drug Administration, be adopted as presented.

Resolution 73-27 was adopted.

#### Resolution 73-27

Food and Drug Administration

RESOLVED, That the Florida Medical Association and the American Medical Association ask their representatives in Washington to seek immediate repeal of the Kefauver-Harris 1962 Drug Amendments; and do further

RESOLVED, That the National Academy of Sciences continue their drug studies and that all regulations of the effectiveness or safety of drugs be placed in such nongovernmental organizations.

Dr. Tate: "The Chairman wishes to express his appreciation to all of the members who appeared before our Committee and to the members of the Reference Committee who worked so diligently."

Upon motion by the chairman, Reference Committee No. II's report was adopted as amended.

Dr. Tate: "Mr. Speaker, this concludes the report of Reference Committee No. II."

# Report of Reference Committee No. III

## Finance and Administration

The Speaker assumed the Chair and called for the report of Reference Committee No. III, Finance and Administration. He announced that Dr. Howard M. DuBose would take Dr. William W. Thompson's place to present the report, as Dr. Thompson, chairman of the committee, was unexpectedly called away from the meeting.

Dr. DuBose came forward to present the report of Reference Committee No. III.

### Report of Board of Governors and Supplemental Report

The Reference Committee considered very thoroughly the Report of the Board of Governors as well as the Supplemental Report of the Board Governors and the accompanying Audit Report for the year then ended December 31, 1972. The Reference Committee recommended that the report of the Board of Governors and the Supplemental Report of the Board of Governors, with the exception of those sections referred to other Reference Committees, be adopted with commendation for a job efficiently done.

The Board of Governors Report and Supplemental Report were adopted.

### Report of Board of Governors

WILLIAM J. DEAN, M.D., *Chairman*

During the Association year, 1972-73, your Board of Governors has held four meetings. The Board met on May 7, October 12-13, 1972, and on January 13, and March 24-25, 1973. Your Executive Committee met in conjunction with each Board meeting. In addition, because of the many crucial issues during the year, the Executive Committee convened for three additional meetings.

Your Officers and Board have worked earnestly and diligently and have strived to keep the best interest of their colleagues uppermost in their actions.

The summary of activities and actions of your Board during the year that are presented in this report, and the many communications to the membership, indicate the many vexing and crucial issues with which organized medicine has come to grips at all levels—national, state and local. Your Board is pleased to report that the year has also been one of progress and productivity at all levels of Association activity.

There is one thing that is abundantly clear to your Chairman amidst all the problems and challenges we are faced with today; our duty is to our patients and the enduring integrity of our profession. To endure, we must be steadfast, with unity as our weapon and the sacred oath of our profession as our armor.

The men who have served on your Executive Committee and Board have acted in every instance with sincere dedication and responsibility. Your Chairman is proud to have served with such physicians.

### MAJOR ACTIVITIES

**Annual Meeting**—The Board approved the format for the 1973 Annual Meeting at its October meeting and urged the Committee on Scientific Assemblies, which is



William W. Thompson, M.D., Ft. Walton Beach (standing) was Chairman of Reference Committee III. His Committee included (left to right): Carl E. Andrews, M.D., West Palm Beach; O. William Davenport, M.D., Miami; Joseph P. Hendrix, M.D., Port St. Joe and Howard M. DuBose, M.D., Lakeland. Mrs. Mary Kay Samorisky served as secretary to the Committee.



responsible for planning the scientific program, to complete the program at the earliest possible date. Some progress has been made toward having the scientific program completed at an earlier date to allow adequate pre-meeting publicity. The specialty groups have indicated their willingness to assist the committee by appointing their program chairmen one year in advance, and also to assist in planning the scientific sections. Your Board will continue its efforts to improve the program and have it completed well in advance.

**FMA Leadership Conference**—The 15th Annual Leadership Conference for county medical society officers and other invited guests was held in Orlando on Saturday, January 27. The annual Legislative Seminar was held the following morning. Among the major topics was an address by the Honorable Emmett Roberts, Secretary of the Department of Health and Rehabilitative Services, covering a wide range of subjects of concern to medicine. Mr. Roberts commended physicians for their efforts in the war on drug abuse and stated that there will always be an open door between his department and the FMA. Of key importance were Mr. Roberts' comments that efforts were being made to lessen some of the inequities in the Medicaid Program.

A vital topic presented was the PSRO (Professional Standards Review Organization) amendment to HR-1 which was signed by the President late in 1972. James B. Byrne, M.D., Chairman of the FMA Committee on Peer Medical Utilization Review, painted a frightening picture of possible future governmental control of the practice of medicine. The meeting was a success again this year and over 96 per cent of the FMA members were represented by their county medical society officers.

Other presentations included a report on the new FMA sponsored Professional Liability Insurance Program and a progress report on the Florida Physicians Association, Inc.

There was a report on the development of the continuing medical education program currently under review and planning by the FMA Committee on Continuing Medical Education. The highlight of Sunday's Legislative Seminar on Medical Legislation was a panel discussion of state and national issues and the individual physician in the political process.

**Financial Statement and Budget**—The Board reviewed the financial statement prepared by the Executive Vice President and approved the auditor's statement presented by the Secretary-Treasurer, prepared by Lucas, Herndon, Harms and Hyers, Certified Public Accountants. This audit report covered calendar year 1972. Association income from all sources was \$647,326.42, and total expenses during the year were \$593,795.28. This gave the Association an excess \$53,531.14 in income over expenses. These figures do not include funds expended for equipment and interest paid as these are carried under fixed assets of the Association.

The Board approved a budget for 1973 totaling \$723,000.00 which is the anticipated income from all sources. In accordance with the By-Laws, the budget was prepared by the Executive Vice President in consultation with the Secretary-Treasurer. It was reviewed by the Executive Committee and approved by the Board of Governors.

Copies of the CPA audit are available to the appropriate reference committee of the House of Delegates and are on file in the Association's headquarters office for review by members of the FMA.

**Appointments**—The Board of Governors named Burns A. Dobbins Jr., M.D. as the AMA delegate to serve on the Board of Governors. Jack A. MaCris, M.D. was appointed as optional member of the Executive Committee.

Named as advisory members to the Board of Governors were Eugene G. Peek Jr., M.D., Department of Health and Rehabilitative Services; Robert E. Zellner, M.D., Blue Shield of Florida, Inc.; and Vernon B. Astler, M.D., Florida State Board of Medical Examiners. James T. Cook, M.D. was designated as Public Relations Officer.

Clyde M. Collins, M.D. was reappointed to his fourth one year term as Editor of *The Journal of the Florida Medical Association*. The Board approved Dr. Collins' nominations of the Committee on Scientific Publications and assistant editors.

Appointed as chairmen of committees of the Board were:

*Subcommittee on Foundations for Medical Care*

James L. Borland Jr., M.D., Chm.

*Subcommittee on Inter-American Relations*

Rufus K. Broadaway, M.D., Chm.

*Subcommittee on Quackery*

Owen F. Agee, M.D., Chm.

*Subcommittee on Venomous Snake Bite*

Carl E. Andrews, M.D., Chm.

*Ad Hoc Committee on Workmen's Compensation*

Joseph G. Matthews, M.D., Chm.

*Ad Hoc Committee on Indian Health*

Richard J. Miller, M.D., Chm.

*Ad Hoc Fla. Physicians Association Planning Com.*

James T. Cook, M.D., Chm.

*Fla. Joint Commission on Medical Education*

Henry R. Cooper, M.D., Chm.

*Committee on Drug Abuse*

Daniel L. Seckinger II, M.D., Chm.

*Ad Hoc Committee on Medicaid*

Allyn B. Giffin, M.D., Chm.

*Ad Hoc Committee on Government Reorganization*

John C. Fletcher, M.D., Chm.

*Committee on Liaison with Osteopathy*

Jerry F. Cox, M.D., Chm.

*Committee on Professional Standards Review Organizations*

Burns A. Dobbins Jr., M.D., Chm.

Francis T. Holland, M.D. and Burns A. Dobbins Jr., M.D. were elected Chairman and Vice Chairman, respectively, of the FMA delegation to the American Medical Association.

## AWARDS

The Board reviewed nominations received from county medical societies and selected therefrom the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the first session of the House of Delegates on May 9, 1973. The recipient for this year's award is included in the delegates' packets.

**Layman's Award**—The House of Delegates in 1972 established a Distinguished Layman's Award. The purpose of the award is to recognize individuals who have made significant and lasting contributions to the medical profession. The House directed the Board to develop the criteria for establishing the award and further that the Board would select the recipient.

The Board has selected the Honorable Verle Pope of St. Augustine, former State Senator, as the 1973 recipient of the Distinguished Layman's Award. The appropriate citation, along with the criteria, is enclosed in the delegates' packets for information.

## NOMINATIONS

The Board's nomination for the physician to receive the Certificate of Appreciation is included in the delegates' packets for presentation at the first meeting of the House of Delegates.

**Committee on Membership and Discipline**—The Board of Governors, pursuant to the instructions of the House of Delegates in 1972, approved interim appointments to vacancies created on the committee because of congressional redistricting. The Board has reviewed terms expiring in 1973 which includes those physicians appointed for interim terms. Nominations from county medical societies have been considered and in accordance with the By-Laws the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated:



## District 1

\*William W. Thompson, M.D., Ft. Walton Beach (74)

\*Philip B. Phillips, M.D., Pensacola (75)

\*Lockland B. Tyler Jr., M.D., Pensacola (76)

†Joseph P. Hendrix, M.D., Port St. Joe (77)

## District 2

\*Louis G. Landrum, M.D., Lake City (77)

## District 3

\*Guy T. Selander, M.D., Jacksonville (77)

## District 4

\*William W. O'Connell, M.D., St. Augustine (77)

## District 5

\*Randall Jenkins, M.D., Inverness (74)

\*Luis M. Perez, M.D., Sanford (77)

## District 6

†Royce Hobby, M.D., St. Petersburg (77)

## District 7

†John T. Wright, M.D., Tampa (77)

## District 8

\*Woods A. Howard, M.D., Lakeland (74)

†Roger A. Meyer, M.D., Bradenton (75)

## District 9

\*W. Dean Steward, M.D., Orlando (75)

\*Lee Rogers, M.D., Rockledge (77)

## District 10

†F. Lee Howington, M.D., Ft. Myers (76)

\*John S. Steward, M.D., Naples (77)

## District 11

\*Ray E. Murphy Jr., M.D., Pompano Beach (76)

\*Reginald J. Stambaugh, M.D., W. Palm Beach (77)

## District 12

\*Robert J. Brennan, M.D., Ft. Lauderdale (77)

## District 13

\*Maurice H. Laszlo, M.D., N. Miami Beach (74)

\*John G. MacLure, M.D., Miami Beach (75)

\*Arthur W. Wood Jr., M.D., Miami Beach (76)

\*Robert M. Lee, M.D., Miami (77)

## District 15

\*Herman K. Moore, M.D., Key West (74)

†John D. White, M.D., Tavernier (77)

\*Nominated for reelection

†New Nomination

**Blue Shield Board of Directors**—The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Nominees for each physician seat were selected as follows:

Medical District B: Thomas E. McKell, M.D.  
Thomas M. Caswall, M.D.  
Medical District D: Jaime M. Benavides, M.D.  
Walter C. Jones III, M.D.  
At Large: Charles K. Donegan, M.D.  
Charles J. Kahn, M.D.  
At Large: Billy Brashear, M.D.  
David A. Giordano, M.D.  
At Large: Warren W. Quillian, M.D.  
J. Champneys Taylor, M.D.

Lay members nominated by the Nominating Committee and approved by the Board are:

Medical District D: Arthur W. Saarinen  
Layman At Large: Lewis A. Doman  
Layman At Large: Tom Tranthan  
Layman At Large: B. G. Smith  
Hospital Administrator  
Blue Cross Bd. Mbr: Bernie B. Welch

**Florida State Board of Medical Examiners**—In compliance with the House of Delegates' policy, the Board of Governors, taking into consideration recommendations by component medical societies, compiled a list of physicians which was forwarded to Governor Reubin Askew for his consideration for appointment to the Florida State Board of Medical Examiners.

## REFERRALS BY HOUSE OF DELEGATES

The 1972 Proceedings of the House of Delegates were reviewed and items requiring study and action were referred to the appropriate committees and councils. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council reports as well as in this report.

**FMA Membership for Medical Students** (1972 Recommendation No. 10, Council on Scientific Activities) [REFERRED TO BOARD OF GOVERNORS]—This recommendation pertains to establishing some type of FMA membership for medical students. This matter has been under consideration by the Council on Scientific Activities. The Council's recommendation, along with the Board's recommendation for disapproval and further study, appears as recommendation No. 3 of the 1973 Annual Report of the Council.

The Board of Governors referred the proposed By-Laws amendments concerning medical student membership and the entire subject of medical student membership to the Judicial Council and Council on Scientific Activities for joint consideration as their recommendations were in conflict. [REFERRED TO BOARD OF GOVERNORS—R.C. I]

**Health & Medical Needs, Retirement Residential Communities** (1972 Recommendation No. 23, Council on Medical Services)—This recommendation pertained to health and medical needs in retirement residential communities and was referred to the Board by the House of Delegates.

## RECOMMENDATION NO. 1

The Board of Governors recommends that the House of Delegates adopt and widely publicize the following statement of position:

The Florida Medical Association has become concerned with the lack of health facilities planning in some retirement residential communities and hereby declares that the provision of adequate health services and facilities should be included wherever any residential community is planned, particularly in the remote areas of Florida. The provision of such health facilities should be paramount in the consideration by the developers of such communities. Too often the health care needs of these residents have been completely ignored.

The Board concurs in the recommendation of the Council on Medical Services pertaining to this policy statement which appears as Recommendation No. 17 of the Council's 1973 Annual Report. (R.C. II)

**Abortion Law** (1972 Recommendation, Reference Committee IV)—This recommendation pertained to the development of "Ethical Guidelines for the Termination of Pregnancies." In consultation with the Council on Medical Services, particularly, the Committee on Mental Health for further criteria, the Judicial Council has developed standards to govern the professional activities of FMA members in view of the abortion act. These "Ethical Guidelines for the Termination of Pregnancies" appear in the 1973 Annual Report of the Judicial Council.

**Needle and Syringe Legislation** (1972 Recommendation, Reference Committee IV)—This recommendation was referred to the Board by the House of Delegates for indepth study.

## RECOMMENDATION NO. 2

The Board of Governors recommends to the House of Delegates that further study of needle and syringe legislation be disapproved.

Resolution No. 72-25, Legislative Session of House of Delegates—This resolution was not adopted but referred to the Board of Governors.

### Resolution 72-25

[NOT ADOPTED—REFERRED TO BOARD OF GOVERNORS]

Legislative Session of the House of Delegates

RESOLVED, That a meeting of the House of Delegates be held several months prior to the convening of the annual regular session of the Florida Legislature, and that such meeting be called in addition to or in lieu of the annual meetings of the House of Delegates which currently are held in conjunction with the scientific program, be it further

RESOLVED, That the pre-legislative session of the House of Delegates be held in conjunction with the Annual Conference of County Medical Society Presidents and Secretaries.

## RECOMMENDATION NO. 3

The Board of Governors recommends to the House of Delegates that Resolution No. 72-25, "Legislative Session of the House of Delegates," be disapproved as being neither practical nor feasible at the present time for the following reasons:

1. Such a meeting would certainly create an added expense to the Association, as well as to the delegates themselves.
2. The resolution itself proposes possible replacement of the House of Delegates meetings held in conjunction with the Annual Meeting. This would decrease the attendance at both the Annual Meetings and the House of Delegates meetings as they complement each other. This would also separate the House from the time of many specialty group meetings.
3. The House of Delegates, for the past several years, has considered in principle almost every conceivable subject that might come before the Legislature. Only a very few subjects of extremely current nature might arise which would not have a policy already established to cover it.
4. Such a meeting of the House of Delegates, if scheduled in lieu of the regular sessions of the House of Delegates, would at least lower attendance at scientific sessions, and would probably mark the end of the technical exhibit program.
5. Specific policies adopted could tie hands of the legislative committee if they referred to specific bills which are subject to change daily.

It is further recommended that as an alternative any member of the House of Delegates that so desires should be invited to the Legislative Workshop that is held in conjunction with the FMA Leadership Conference in January of each year.

Resolution No. 72-11, Medicare Terminology—More Than Allowable Charge—This resolution was not adopted by the 1972 House of Delegates but referred to the Board of Governors. The resolved of this resolution provides that an explanation of "more than allowable charge" be made available to Florida physicians for distribution to their patients.

## RECOMMENDATION NO. 4

The Board of Governors recommends to the House of Delegates that the Florida Medical Association prepare and print a brochure explaining the phrase "More than allowable charge" with each major point explained in a short paragraph (possibly a question and answer approach). This brochure would contain the Florida Medical Association seal indicating that this was prepared by the Florida Medical Association to explain the phrase "More than allowable charge" to the patients of Florida physicians. (R.C. V)

Dissemination of Information to Membership—This was a recommendation of the Council on Medical Services in its 1972 Annual Report that the Board of Governors study and effect an improved means of disseminating information to the membership following each legislative session concerning new laws affecting the medical profession.

## RECOMMENDATION NO. 5

The Board of Governors recommends that the House of Delegates reaffirm FMA's policy that a summary of legislative sessions be forwarded to each FMA member as well as appropriate publicity in the FMA Journal.

## MAJOR ACTIVITIES

1. Peer Medical Utilization Review—The Board approved a letter agreement with the Florida Medical Foundation to provide executive staff to administer the Peer Medical Utilization Review Contract with Blue Shield of Florida, Inc. and the Department of Health, Education and Welfare.

The Board adopted a policy statement that Blue Shield request institutional records in peer review cases; and that such records be made available to the county and state peer review committees. The Board also endorsed Blue Shield's intent to offer physicians scheduled for peer review referral the opportunity of submitting office records of summaries prior to a final decision to refer cases.

Under the contract for peer review between the Florida Medical Foundation, Blue Shield and the Department of Health, Education and Welfare, the FMA Committee on Peer Medical Utilization Review was authorized to participate in a survey of medical practice at Mount Sinai Hospital in Miami Beach from a professional standpoint only. (R.C. V)



2. Ad Hoc Committee on Workmen's Compensation—The Board expressed its appreciation to the committee; in particular its Chairman, Joseph G. Matthews, M.D., and to FMA Legal Counsel, for their accomplishments in revision of the Workmen's Compensation Fee Schedule. (R.C. V)

3. Resolution No. 72-32, Medicare—Explanation of Medical Benefits—The House of Delegates adopted Resolution No. 72-32, Medicare—Explanation of Medical Benefits. The resolution called for Blue Shield of Florida to make available to nonassignment physicians when duly authorized in writing by the beneficiary, a copy of the summary report. This resolution has been referred to FMA delegates to the AMA for consideration and referral to AMA at the appropriate time. It was also referred to the Blue Shield representatives on the Board. (R.C. V)

4. Community Health Education Act—The Board gave approval for the Florida Medical Foundation to enter into a letter agreement or contract with the State University System of Florida, specifically the Board of Regents, fiscal agent of the CHEA. The Foundation would assist in improving the overall quality and attractiveness of educational programs for interns, residents and attending staff of community hospitals in Florida. The Foundation would also serve in a fiscal capacity for administration of the program. The Board of Regents has requested the Foundation to draft a contract which has been accomplished. The Vice Chancellor for Medical Affairs of the Board of Regents, however, has not responded to date regarding execution and implementation of the agreement which he proposed. (R.C. I)

5. FMA Commemorative Plaque—The Board participated in ceremonies in Jacksonville on October 15, 1972, for the unveiling and dedication of a commemorative plaque placed at the site of the founding of the FMA in 1874.

6. Delegates Apportionment—The Board reviewed the 1:40 ratio for delegates representing county medical societies. It was deemed unnecessary to revise this ratio at the present time.

7. AMA Membership and Delegates—Florida's AMA membership has remained sufficient to insure the FMA of six delegates to the AMA House of Delegates. The Board and Officers of the Association have emphasized to the membership the importance of support and membership in the AMA.

8. Council of Medical Staffs—In response to a request from the Council of Medical Staffs to have material published in the FMA Journal, the Board responded by advising, "*The Journal of the Florida Medical Association* will publish any material at any time from any organization which augments or implements the purposes and policies of the Association."

9. Medicare Disclosure Regulations—The Board has made official protests against proposed regulations that would make it mandatory that Medicare disclose at the local level the names of doctors who had been subjected to peer review. The Board pointed out that such requirements would destroy the peer review process in Florida. Similar letters of protest have been sent by Blue Shield and the Florida Hospital Association.

10. Committee on Liaison with Osteopathy—As directed by the House of Delegates, a Committee on Liaison with Osteopathy was appointed. This committee met with the liaison committee of the Florida Osteopathic Medical Association in Orlando. The Board feels this to be a significant step toward better cooperation and understanding between the two professions. The Board concurs with the opinion of the Committee on Liaison with Osteopathy that future joint meetings with the liaison committee of the Florida Osteopathy Medical Association are desirable.

## RECOMMENDATION NO. 6

The Board of Governors recommends that the Florida Osteopathic Medical Association

tion be encouraged to prepare an essay explaining the nature of osteopathic education, licensing and practice; that this essay be duplicated and mailed, at the expense of the Florida Osteopathic Medical Association, to all members of the Florida Medical Association; that this material be distributed at the invitation of the Florida Medical Association; and that the Florida Medical Association make its mailing list available for this purpose.

11. State Renal Disease Council—The House of Delegates in 1972 expressed the need for a pediatrician to be appointed to the State Renal Disease Council and that this program be placed under professional medical administration. Sidney Levin, M.D., Jacksonville pediatrician, has been appointed to a four-year term on the Council. The Board has also received a letter from the Department of Health and Rehabilitative Services advising that they have this subject under study.

12. AMA Delegates—The Board commended the entire Florida delegation for its hard work in serving Florida in the AMA House of Delegates. Congratulations were extended to Jere W. Annis, M.D., who has been elected to a full term on the AMA Board of Trustees and to Burns A. Dobbins Jr., M.D. on his election to the AMA Judicial Council.

13. Florida Physicians Association, Inc.—The House of Delegates in 1972 adopted in principle Resolution No. 71-4 and directed that the FMA organize and sponsor a corporation dedicated to the private practice of medicine. The corporation is to be known as the Florida Physicians Association, Inc. and is to be directly responsible to the FMA. To carry out the directives of the House, a special Ad Hoc Florida Physicians Association Planning Committee was appointed.

This committee has worked diligently to establish a viable organization that will not only fully implement its intended purposes, but also comply fully with the intent and directions of the House of Delegates.

The report of the committee along with the Board's commendation and full support for approval is printed in the Delegates' Handbook.

14. Current Changes in Medical Education—This has been referred to the Association's Committee on Medical Schools and is currently under study. In addition, the FMA Delegates to the AMA introduced a resolution to the AMA which was combined with a similar resolution from California and passed as a substitute resolution which was acceptable. The resolved of the resolution provides, "That careful study and evaluation be made by the American Medical Association of present trends in medical education to include (1) medical school curriculum content, (2) abbreviated curricula, and (3) postgraduate education; and, above all, to maintain the excellence of quality of medical education involved." (R.C. I)

15. Resolution No. 71-24, Medicare Program Benefits—

## Resolution 71-24

### Medicare Program Benefits

Whereas, Under Medicare Part B of the Social Security Act, Insurance Companies, Corporations and Individuals who have incurred medical bill responsibility as a result of liability can have these paid by Medicare, and

Whereas, This Medicare program should be utilized for those eligible for its benefits and not for relief of defendant Carriers, Corporations or Individuals, and

Whereas, People provided for under various Workmen's Compensation Laws are not eligible for Medicare benefits, therefore be it



RESOLVED, That the Florida Medical Association go on record favoring immediate plugging this inequitable loophole in the Medicare law which permits such as mentioned from escaping their due responsibility when liable, and be it further

RESOLVED, That the Senators and Congressmen from the State of Florida be promptly informed of the sense of this resolution so that legislative action may be initiated for preventing this drain on the Medicare program.

The Board of Governors transmitted to the Florida Congressional Delegation this resolution. Each member considered the information extremely helpful as background resource for any legislation pertaining to this subject. Congressman Bennett and Congressman Haley forwarded this material to Commissioner Robert M. Ball of the Social Security Administration.

So that the House of Delegates might be apprised, the following is a summary of Commissioner Ball's reply to Congressman Haley:

The view that Medicare should not pay for medical care for which some other organization or individual is liable is not an unreasonable one. However, a provision to preclude Medicare payments in such cases would be extremely difficult to administer, and the administrative cost will outweigh any savings to the program.

Collection in individual tort cases would present special problems; yet, if the principle that Medicare should not pay where someone else was legally liable were adopted, it would seem necessary to apply the principle to all kinds of situations. On the other hand, if, where the circumstances indicated the possibility of third-party liability, the Medicare payment were to be delayed until the extent of third-party liability was established, beneficiaries and those providing services might not know for long periods what the source of payments would be—a situation that would be clearly undesirable.

Another problem is that many third-party liability claims are settled by insurance companies or by the courts in the form of lump-sum payments for medical and hospital expenses which may or may not be covered under Medicare, including amounts for "pain and suffering," "mental anguish," loss of services, etc. Settlements may cover certain medical expenses but the factual basis for the settlement is frequently what the claimant considers an acceptable net receipt. It would be virtually impossible in these cases to determine what proportion of the award was for expenses covered under Medicare and it would be inequitable to assume that the entire amount paid under Medicare was recoverable. (R.C. V)

16. Quackery—The Board, through its Subcommittee on Quackery, has endeavored through liaison with the Bureau of Comprehensive Health Planning and legislative leaders to bring about in 1973 a study on the scope and role of chiropractic practice in the State of Florida and the need for such.

17. Florida Regional Medical Program and Comprehensive Health Planning—The Board has kept abreast of the activities of the Florida Regional Medical Program. Letter agreements between the Florida Medical Foundation and Florida Regional Medical Program are outlined in the Foundation's Annual Report. Current plans for phasing out the Regional Medical Program were reviewed.

The Board has also been attuned to the activities of Comprehensive Health Planning and has discussed proposals for discontinuing this program.

#### RECOMMENDATION NO. 7

The Board of Governors recommends to the House of Delegates that the Florida Medical Association take the position that the Regional Medical Program should be discontinued, and

that the Association recognizes significant contributions made by the Florida Regional Medical Program, particularly during the past two years. (Amended by R.C. I)

#### RECOMMENDATION NO. 8

The Board of Governors recommends to the House of Delegates that the Federal Comprehensive Health Planning Program be discontinued. (R.C. IV)

#### RECOMMENDATION NO. 9

(Comprehensive Health Planning)

Doctors of Medicine are the most qualified people in any community to determine the medical facilities necessary and the Florida Medical Association recommends that county medical societies should work diligently toward efficient utilization of medical facilities in their community; and further, that where there are existing local Comprehensive Health Planning 14-B agencies, the county medical societies and individual physicians should be encouraged to continue to participate actively and assume a leadership role.

18. Statewide Health Education Conference—The Board approved a request of the Woman's Auxiliary to the Florida Medical Association, Inc. that FMA co-sponsor, along with the Auxiliary, the Division of Health, the Florida Regional Medical Program and the Department of Education, a statewide health education conference. This highly successful conference on health education was held on March 15-16, 1973, in St. Petersburg and had as its central theme a focus on the complex health problems of Florida's youth.

#### RECOMMENDATION NO. 10

The Board of Governors recommends to the House of Delegates that the Florida Medical Association approve the following recommendations of the First Annual Statewide Health Education Conference:

- (1) That this Conference endorses the development of a comprehensive, adequately funded health education program for the schools of Florida and fully supports the legislation and appropriations required to accomplish this, utilizing in this effort the many community, organizational and professional resources within the state.
- (2) That this Conference commends the Woman's Auxiliary to the Florida Medical Association for its initiative in taking the lead in sponsoring this Conference and for its devotion and energy which have made this Conference such a success.

That the Florida Medical Association receive as information an addendum to the recom-

mendation of the Conference a concept emphasizing the need for cooperation among all organizations in the health field. Experience in other areas has clearly demonstrated that the key to a successful comprehensive school health education program is cooperation among all organizations and interests rather than competition for curriculum time which results in fragmentation and ineffectiveness of the health educational effort. The Board of Governors recommends to the House of Delegates that the Woman's Auxiliary to the Florida Medical Association be commended for an outstanding health education workshop held in St. Petersburg, March 15-16, 1973. (R.C. I)

19. **Legislation**—In addition to the major legislative objectives for 1973, which are outlined in the Annual Report of the Council on Legislation and Public Agencies, the Board has taken the following actions:

[second paragraph deleted]

**Department of Health**—The newly appointed Ad Hoc Committee on Government Reorganization has been charged with the responsibility of seeking a legislative study of the need for a separate Department of Health to serve as a basis for the FMA policy to establish such a department.

**Legislative Brochure**—An appropriate brochure has been published outlining the 1973 Legislative Program and objectives of the FMA. The brochure has been distributed to members of the Florida Legislature and other interested parties. (R.C. IV)

20. **Congressional Visitation (1973)**—The 20th Congressional Visitation Luncheon with members of the Florida Congressional Delegation was held on Monday, March 12, and was most successful. The visit followed the AMA-AMPAC Workshop on March 9, 10 and 11.

21. **New Professional Liability Insurance Program**—The new FMA sponsored Professional Liability Insurance Plan for members of the Association was approved by the Board of Governors and appropriate contracts were executed with Argonaut Insurance Company, which is now underwriting the program.

This program was carefully designed and negotiated specifically to meet the needs of our members by appropriate Association representatives; many are of the opinion that it is not only unique but also the finest such program in the United States today. The Association was able to obtain every provision it sought for this model program.

Harlan Inc. of Florida, with more than 28 affiliates in Florida, will administer the program with active participation by the Florida Medical Association.

Each member who was insured by the Employers Fire Insurance Company under the former FMA sponsored program had his new policy issued effective January 1, 1973, based upon the application then on file and by completing a simple application form. Others applying for the coverage under this program must complete a new form and have it submitted through their county medical societies.

Special features of the program are as follows:

- (1) A 10 per cent reduction in premiums for those insured under the former program.
- (2) Option to pay premium quarterly with no penalty or interest charge.
- (3) Minimum limits of \$100,000/\$300,000 up to \$1,000,000 in the primary contract.
- (4) Umbrella coverage will be available from primary limits of \$100,000/\$300,000 up to a maximum of \$5,000,000.
- (5) Premises liability will be included at a nominal annual premium. This will have the same limit of liability as the basic professional liability policy.

- (6) Individual policies will be issued for each doctor in a partnership or Professional Association. In addition, a policy will be issued in the name of the partnership or Professional Association.
- (7) Centralized claims handling.
- (8) Centralized coordination of legal defense.
- (9) Program guaranteed minimum of five years.
- (10) Centralized administration of all aspects of the program with the Medical Association's active participation.
- (11) Medical Society determination of "chargeable losses" of individual physicians.
- (12) Complete financial disclosure of the program.
- (13) Participating in savings, if any, at the end of a specified time.
- (14) Immediate service through toll-free WATS line.
- (15) Active defense of all non-meritorious suits. (R.C. V)

22. **FLAMEDCO, Inc.**—The House of Delegates in Executive Session last year authorized the formation of a stock corporation for profit wholly owned by the Florida Medical Association to conduct appropriate business on behalf of the Association. This Corporation was formed and called FLAMEDCO, Inc. It is currently serving as the general agent for the FMA Professional Liability Insurance Program and owns the application forms and the retention of business. The Association is in the process of activating a life program and will transfer other insurance programs to this company when indicated. FLAMEDCO actively participates in the administration of the PLI program. (R.C. V)

23. **Johnson Foundation Grant**—The Board authorized the Foundation to accept up to \$25,000 from the Johnson Foundation to complete the study provided for in the PRES contract which has expired, specifically, experimentations with the proper utilization of terminal inputs for a computerization system.

24. **FMA Travel**—Sponsorship was approved for a Medical Seminar to France, Switzerland and Spain, April 6-15, 1973. Approval was given to the Woman's Auxiliary to sponsor a Medical Seminar tour to Alaska and Japan August 18 to September 2, 1973. Profits derived from these tours will be donated to the Florida Medical Foundation.

25. **Insurance Review Procedures**—The Board adopted operating procedures to be used by the Association's Committee on Health Insurance. The procedures are intended to assist the Committee in resolving disagreements between physicians and the Health Insurance Industry. (R.C. V)

26. **PMUR Operating Procedures**—The Board has adopted PMUR operating procedures to be followed by the Association and the Florida Medical Foundation under its contract for peer medical utilization review. (R.C. V)

27. **Council of 100**—The Board authorized the Association to obtain sponsorship and appointment of a member of the Association to the Council of 100.

28. **Richard T. Shaar, M.D.**—The Board noted with regret the death of Richard T. Shaar, M.D., Senior Medical Consultant for Blue Shield. Dr. Shaar's arduous efforts contributed greatly to better understanding between Florida physicians and Blue Shield. His valuable presence among physicians will be sorely missed.

29. **Alfred L. Lewis Jr., M.D.**—A special resolution was adopted regarding the untimely death of Dr. Lewis, who had served organized medicine at many levels in an exemplary manner.

30. **PSRO (Professional Standards Review Organization)**—After long and arduous deliberation, your Board of Governors reluctantly authorized the establishment at the earliest possible date of the Florida Professional Standards Review Organization, Inc. This organization will file an application with the Department of Health, Education and Welfare to be designated as the professional standards review organization for the State of Florida based on Public Law 92-603 (HR-1). The primary purpose of this corporation is to serve as the prime contractor for the State of Florida, providing all statistical, computer and support services to and for not less than 12 local PSRO's who shall provide all local review and professional services. (R.C. V)



31. Florida State Hospital at Chattahoochee—The Association has requested the Secretary of the Department of Health and Rehabilitative Services, to retain experienced defense counsel to assist staff counsel in the appeal of the suit in the U.S. District Court—Kenneth Donaldson vs. J. B. O'Connor, M.D. Dr. O'Connor was Superintendent of the State Hospital at Chattahoochee when a malpractice suit based upon an inmate's civil rights was filed against him. FMA Legal Counsel has been requested to review the case for possible assistance and to determine what implications the suit may have on the practice of other physicians in Florida.

32. FMA Medical Districts—Membership in the four FMA medical districts was reviewed and the increases or decreases in membership were noted. The Board did not feel that it was necessary to consider redistricting at this time.

DISTRICT	MEMBERSHIP		DIFFERENCE
	JAN. '72	JAN. '73	
A-North	1,458	1,538	+ 80
B-West	1,881	2,063	+182
C-East	2,152	2,368	+216
D-South	2,140	2,392	+252

33. Acupuncture—The Board reviewed a recommendation from the Subcommittee on Quackery regarding the practice of acupuncture.

#### RECOMMENDATION NO. 11

The Board of Governors recommends to the House of Delegates that the Florida Medical Association adopt a position of policy to the effect that acupuncture has been determined to be a medical procedure to be used only by physicians holding unrestricted and unlimited licenses to practice medicine, or individuals acting under their direct supervision; and that the Florida Medical Association, in the absence of adequate scientific information at the present time, is unable to vouch for the therapeutic or anesthetic value of acupuncture.

34. Blue Shield—The Board is pleased to report that the Committee on Advisory to Blue Shield and Fiscal Intermediaries (Committee of 17) has continued to be an effective liaison link between FMA and Blue Shield. The summary of activities of the committee are included in the Annual Report of the Council on Medical Economics. The following is a brief summary of actions taken by the Board regarding Blue Shield. Also included are reports received from Blue Shield on referrals.

- (1) Blue Shield Review Mechanisms—Requested the Blue Shield Board to reevaluate its review mechanisms to insure adequate medical review.
- (2) Medical Consultants—The Board of Governors recommended to the Blue Shield Board that they diligently seek additional medical consultants to assist Thomas M. Irwin, M.D., Vice President-Medical Director, and facilitate claims review.
- (3) Manual on Claim Forms—The Board recommended to Blue Shield that a manual be prepared and made available to physicians, on the proper preparation of claim forms that are being processed by Blue Shield for either private business or government programs which Blue Shield administers, and that it be broken down by specialty.
- (4) Complementary Coverage—The Board agreed with Blue Shield that it would be inadvisable for the complementary coverage contract to pay the Medicare \$50 deductible. The Board recommended to the Blue Shield Board that it look into implementing, if possible, complementary

coverage up to the level of the 90th percentile of U.C.R. rather than Medicare "reasonable" charge levels.

Blue Shield has reported that it is not known if there is a consumer demand for this. A market survey has been authorized. The results of the survey should be available in late Spring.

- (5) Resolution No. 72-17, Blue Shield Contract Coverage—Resolution No. 72-17 passed by the House of Delegates recommended to Blue Shield that all contracts providing essentially less than 50 per cent prepaid coverage be phased out and that all new contracts provide usual, customary and reasonable coverage; a coverage that will provide at least 60 per cent of usual, customary and reasonable fees.

#### RECOMMENDATION NO. 12

The Board of Governors recommends to the House of Delegates that Resolution 72-17, Blue Shield Contract Coverage, be reaffirmed and that Blue Shield's suggestion of implementing this resolution basing it on 60 per cent of U.C.R. premium rather than 60 per cent of U.C.R. benefits, was a practical method of accomplishing the intent of the resolution.

- (6) Social Security Administration Regulations—Blue Shield has been requested to protest to the Social Security Administration, on the Association's behalf, regarding the regulation of physicians witnessing the mark of illiterate or physically handicapped patients.
- (7) Blue Shield Psychiatry—The Board has recommended to the Blue Shield Board that in light of the problem in psychiatry where obsolete terminology in contracts create loop holes inviting future law suits, it is felt that it would be advisable if the Board of Blue Shield institute a review of the existing contract terminology, and secure consultation with the various specialty groups if necessary.
- (8) Blue Shield Contracts—The Board noted that in old contracts there is no update automatically under Blue Shield, as with 'he concurrently sold part of the contract for Blue Cross, and the Board expressed to the Blue Shield Board the gross inequities in this and recommended that efforts be made to correct these inequities. Blue Shield reports that an interim update program has been delayed in its implementation because of questions which have arisen with respect to its relationship to the Wage-Price Freeze. Further consideration will be required on this subject because of these regulations. Blue Shield will reconsider this update as soon as clearance from the government has been received.
- (9) Resolution No. 72-6, Medicare Directives—This resolution was adopted by the House of Delegates in 1972 and resolved that all Medicare directives be published 30 days before going into effect and circularized to all physicians and hospitals with an envelope stamped in red, "Medicare Directive." Blue Shield has advised that such a request was submitted to Mr. Douglass M. Richard, the Regional Representative, Social Security Administration. Mr. Richard advised the following:  
 "... it seems to me impossible for you to publish and distribute all Medicare directives 30 days before they go into effect. As you well know, many of our policy decisions are



made in response to specific problems that have arisen and are effective when they are published."

Blue Shield is in accord with the sentiment behind this resolution, but it is impossible for them to implement under the circumstances that exist at the present time.

- (10) Notification to Doctor—Blue Shield has been requested that when the patient is contacted by phone to verify services, that the doctor be notified.

- (11) Resolution No. 72-35, Standard Attending Physician's Form—This resolution was passed by the House of Delegates and requests Blue Cross and Blue Shield consider redesigning their attending physician's forms to fit as closely as possible the general format of the standard form as designed by the AMA and the Health Insurance Council. Blue Shield is aware that there is a standard form being prepared by the American Medical Association, the National Association of Blue Shield Plans, and the Health Insurance Council but it is not yet available. When it becomes available, Blue Shield will determine the feasibility of its adoption for use by Blue Shield. (R.C. V)

35. Medicare Contract—The Board gave serious consideration as to whether or not Blue Shield should renew its contract with the Department of Health, Education and Welfare to serve as fiscal administrator in Florida.

#### RECOMMENDATION NO. 13

The Board of Governors recommends to the House of Delegates that Blue Shield renew the contract with the Department of Health, Education and Welfare to continue as fiscal administrator for Medicare provided it is in the best interest of the physicians of Florida. (R.C. V)

36. Dual Fee Schedule—The Board reviewed correspondence from the Department of Health, Education and Welfare to Blue Shield indicating possible implementation of a dual fee schedule in Florida.

#### RECOMMENDATION NO. 14

The Board of Governors recommends to the House of Delegates that if the Department of Health, Education and Welfare insists upon a dual fee schedule in Florida that Blue Shield terminate the Medicare contract. (R.C. V)

#### RECOMMENDATION NO. 15

(By-Laws Amendments)

After careful consideration of proposed amendments to the FMA By-Laws, the Board of Governors submits the following recommendations for amendments:

#### CHAPTER I—MEMBERSHIP, Section 2—Classifications

Amend Item No. 1 to read:

"1. Regular Active Dues-Paying Members.—Active Members shall be those Florida Licensed Doctors of Medicine who are certified to the Association by the several component society secretaries as unrestricted members in good standing AND

WHO FULFILL THE CONTINUING MEDICAL EDUCATION REQUIREMENTS FOR MAINTENANCE OF MEMBERSHIP . . . (remainder of paragraph to remain unchanged)"

#### CHAPTER VII—BOARD OF GOVERNORS, Section 2—Duties and Functions

Amend by adding an Item No. 10 to read:

"10. THE BOARD OF GOVERNORS SHALL APPOINT ANNUALLY FROM THE MEMBERSHIP AT LARGE A HISTORIAN, WHOSE DUTIES SHALL INCLUDE APPROPRIATE COMMEMORATIVE OBSERVANCES, LIAISON WITH THE EDITOR FOR PUBLICATION OF HISTORICAL MATERIAL, THE HISTORY OF MEDICINE IN FLORIDA IN GENERAL, AND OTHER RESPONSIBILITIES AS DESIGNATED BY THE BOARD OF GOVERNORS."

#### CHAPTER VIII—COUNCILS

Section 1, Organization—Amend by DELETING Item 7, Special Activities.

Section 3, Duties and Functions—Amend by DELETING this section, and renumbering the remaining paragraphs.

#### CHAPTERS IX—COMMITTEES

Section 1, Organization

Amend by DELETING the eighth paragraph, which reads "The Council on Special Activities: Committee on Archives and Board of Past Presidents."

Amend the tenth paragraph, Council on Specialty Medicine, to read:

"Each representative on the Council on Specialty Medicine shall be elected annually by the Specialty Group which he represents, and may be reelected to as many terms as the represented organization so desires. AN ALTERNATE REPRESENTATIVE MAY BE SELECTED AT THE SAME TIME AND REPORTED ALONG WITH THE REGULARLY ELECTED REPRESENTATIVE."

Section 2, Composition, Selection and Tenure of Committees

Amend Item No. 7, by adding:

THE BOARD OF PAST PRESIDENTS SHALL COMPRISE A SPECIAL STANDING COMMITTEE OF THE BOARD OF GOVERNORS, RESPONSIBLE DIRECTLY TO THE EXECUTIVE COMMITTEE AND THE BOARD OF GOVERNORS."

Section 3, Duties and Functions

Amend Item No. 11, by adding:

"... AND PERFORM SUCH OTHER DUTIES AND FUNCTIONS AS REQUESTED BY THE BOARD OF GOVERNORS."

## Supplemental Report Board of Governors

### NOMINATIONS

Judicial Council—In compliance with FMA By-laws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1973.

The Board nominates John J. Cheleden, M.D. of Daytona Beach to the House of Delegates for reelection to the Judicial Council for Medical District C for a five year term following his current term which expires in 1973.

### MAJOR ACTIVITIES

(The following actions of the Board are submitted to the House of Delegates in addition to those listed in the Delegates Handbook.)

FMIT Program—The Board of Governors had reviewed and investigated the coverages and proposed increases in rates in the Florida Medical Insurance Trust.

The Board approved recommendations as follows: (R.C. V)

The rates of Blue Cross, Blue Shield and Master Medical will be increased effective July 1, 1973 in view of past claim experience.

The present High Option Plan provides for full payment of a semi-private hospital room.

#### RECOMMENDATION NO. 16

That this be placed on an 80-20 co-insurance basis for the semi-private daily room allowance benefit with the co-insurance not being eligible for major medical benefits.

This will reduce the monthly rate for single coverage by \$1.10 and the family coverage by \$2.84.

This would not have any effect on the Low Option Plan since there is a maximum benefit already established on room and board.

In reviewing the Master Medical Experience, it was found that 62.4% of the total paid was for nervous and mental benefits.

#### RECOMMENDATION NO. 17

That both in-patient and out-patient benefits for this condition be eliminated from the master medical coverage.

The basic Blue Cross would still provide for hospital admissions in connection with mental and nervous conditions for a period up to 31 days per contract year. By eliminating the in-patient and out-patient benefits from the Master Medical the monthly rates would be reduced \$1.22 for single coverage and \$3.18 for family coverage.

The above will result in the following monthly premiums.

	HIGH OPTION	LOW OPTION
Single	\$21.70	\$15.40
Family	\$69.32	\$40.89

It was requested that the FMA be furnished a quarterly claims report for this program. These can be reviewed by a designated committee to recognize possible trends in certain areas before they result in future premium increases.

Proposed rates for current program were:

	HIGH OPTION	LOW OPTION
Single	\$24.02	\$16.62
Family	\$75.34	\$44.07

PMUR—Mount Sinai Hospital—The Board of Governors has reviewed the request from the President of Blue Cross that Florida Medical Foundation release the names of those physicians who served on the PMUR Committee for the physicians reviewed at Mount Sinai Hospital in Miami Beach. (R.C. V)

The Board of Governors adopted the following position:

- (1) That FMA not release the names of the physicians used in the PMUR survey at Mt. Sinai, request Blue Shield not to release the names, and request the Social Security Administration not to release the names of the physicians.
- (2) That in the event Blue Shield or the Social Security Administration releases these names other than upon court order, FMA will have to reconsider its position as to whether Blue Shield should be carrier for Medicare and also review the continuation of the PMUR contract with Blue Shield.
- (3) That a letter be sent to the physicians involved to advise them of this action, along with a copy

of the letter from the attorneys for Mt. Sinai requesting names and other information, and instructions approved by FMA Legal Counsel.

Blue Shield—UCR Programs—The FMA Committee of 17 has conducted an extensive study into all aspects of the Blue Shield Usual, Customary and Reasonable Programs, including the methods used for making determination of individual and community fee profile allowances, as well as the conduct of Blue Shield claims review. (R.C. V)

#### RECOMMENDATION NO. 18

That FMA convey a vote of confidence in the Blue Shield staff for the efforts it has given in the overall development of the Blue Shield UCR system. In UCR determinations, no percentile less than the 90th shall be used.

That FMA recognizes along with Blue Shield, that many problems have been solved and that a constant effort is being made by Blue Shield to correct deficiencies in the program.

That FMA reaffirms its endorsement of the Blue Shield UCR approach to meeting the health care needs of the citizens of Florida and the nation, its commitment to continue studying ways to improve the program.

The Reference Committee considered the report of President William J. Dean, M.D., as given in his address to the First House of Delegates on Wednesday, and recommended that his address be adopted as presented, with the sincere appreciation of the House for the special motivation and true inspiration which it supplied.

It was adopted. (The President's address begins on page 21).

#### Remarks of the Speaker

The Reference Committee heard the Remarks of the Speaker of the House as presented to the House of Delegates at its First Meeting on Wednesday, and expressed its gratitude for the helpful instructions, information and cheerful manner contained therein.

The Speaker's remarks were adopted as presented. (The Remarks of the Speaker appear on page 26).

#### Report of the Board of Governors Representative from the State Board of Medical Examiners

Upon recommendation of the Reference Com-



mittee, the report of the Board of Governors representative from the State Board of Medical Examiners was filed.

### Committee on AMA House of Delegates

Upon recommendation of the Reference Committee, the report of the Committee on AMA House of Delegates was filed.

### Florida Medical Foundation

Upon recommendation of the Reference Committee, the report of the Florida Medical Foundation was filed.

### Florida Physicians Association, Inc.

Upon recommendation of the Reference Committee, the report of the Florida Physicians Association, Inc., was adopted, with commendation for a productive report.

[The Board of Governors has approved the following report of the Florida Physicians Association, Inc., and submits it to the House of Delegates with its unanimous commendation and full support.]

## Florida Physicians Association, Inc.

JAMES T. COOK, M.D., *President*

The House of Delegates in 1972 adopted the Board of Governors recommendation concerning Resolution 71-4, which stated:

"That the FMA organize and sponsor a corporation dedicated to the private practice of medicine in Florida; that the membership of this corporation be restricted to FMA members with voluntary participation; and that this corporation be directly responsible to the FMA. The corporation will be known as the Florida Physicians Association, Inc."

Pursuant to this action, representatives of the Florida Medical Association secured, in January 1973, the incorporation of the Florida Physicians Association, Inc., under the laws of the State of Florida.

FPA's multiple purposes and functions were enumerated in the 1972 report of the Board of Governors and have since been restated in a mailing to the membership of the Florida Medical Association last January.

Temporary officers and other incorporators of FPA are: James T. Cook, M.D., Marianna, President; Jack A. MacCris, M.D., St. Petersburg, Vice President; Paul C. Harding, M.D., Orlando, Secretary; Thad Moseley, M.D., Jacksonville, Treasurer; Robert L. Andrae, M.D., Fort Lauderdale; and Harold A. Yount, M.D., West Palm Beach. These physicians will continue to manage FPA's affairs until the properly constituted Board of Directors is installed.

**Membership Promotion:** FPA's membership promotion effort has included at least two major elements. The President and Vice President of FPA published in the December 1972 issue of *The Journal of the Florida Medical Association* an article entitled "Florida Physicians Association, Inc." This essay included a brief account of events leading up to the formation of FPA and presented a candid analysis of the organization's possibilities and limitations.

The second promotional element was a membership solicitation mailed to all members of the Florida Medical Association in January. This mailing included (1) a letter signed by the President of FPA inviting FMA members to join, (2) a reprint of the article in the December 1972 issue of JFMA, and (3) a participation agreement to be signed by the doctor and returned to FPA with \$15.00 annual membership dues.

FPA membership is categorized as to congressional district. As participation agreements are returned to FPA, they are filed by the staff under "Congressional District 5" or whatever the case may be. This is done in this manner because the majority of members of the Board of Directors (15) are to be chosen as representatives of the various congressional districts. As of March 12, 1973, a total of 743 physicians were on the FPA membership rolls.

Divided by congressional districts, the membership is as follows:

Congressional District & Counties	FPA Members
District 1 (Escambia, Santa Rosa, Okaloosa, Walton, southwestern part of Holmes, Washington, Bay, southern part of Gulf)	38
District 2 (Northern part of Gulf, northeastern part of Holmes, Jackson, Calhoun, Liberty, Leon, Franklin, Gadsden, Wakulla, Jefferson, Madison, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Baker, Union, Bradford, Alachua)	34
District 3 (Nassau and all but southeastern part of Duval)	24
District 4 (Southern part of Duval, Clay, St. Johns, Putnam, Flagler, Marion, northeastern part of Lake, Volusia)	62
District 5 (Northern part of Pinellas, Pasco, Hernando, Citrus, Sumter, southwestern part of Lake, northwestern and central part of Orange, Seminole)	31
District 6 (Southern part of Pinellas)	52
District 7 (Hillsborough except southeastern part)	35
District 8 (Southeastern part of Hillsborough, Polk, Manatee, Hardee, extreme northern tip of Sarasota)	53
District 9 (Brevard and eastern part of Orange)	55
District 10 (Southwestern corner of Orange, Osceola, Indian River, St. Lucie, Okeechobee, Highlands, DeSoto, all but northern tip of Sarasota, Glades, Charlotte, Lee, Hendry, Collier, Martin, northeastern part of Palm Beach)	42
District 11 (Northeastern part of Broward and all but northeastern part of Palm Beach)	38
District 12 (All but northeastern part of Broward)	39
District 13 (Northeastern corner of Dade)	19
District 14 (Lower northeastern portion of Dade)	21
District 15 (Monroe and all but northeastern Dade)	29
District Undetermined	171

**Board of Directors:** FPA's Articles of Incorporation provides for a Board of Directors consisting of not less than 20 nor more than 25 members. This includes one member from each of the 15 congressional districts, four officers (president, vice president, secretary and treasurer), three appointees of the Florida Medical Association, and one appointee of the Florida Medical Political Action Committee. All appointments to the Board of Directors are subject to approval of the Florida Medical Association.



Nominations for Board seats representing congressional districts are made jointly by the presidents of the county medical societies in each district. The following physicians have been nominated for the Board of Directors and these nominations have been concurred in by the Board of Governors:

By the President of the Florida Medical Association	1. David T. Overbey Jr., M.D., St. Petersburg
	2. O. William Davenport, M.D., Miami
	3. Charles J. Kahn, M.D., Pensacola
By the President of FLAMPAC	William H. Harrison, M.D., Daytona Beach
County Medical Society Presidents in District—	
District 1	
District 2	Taylor H. Kirby, M.D., Gainesville
District 3	
District 4	
District 5	
District 6	
District 7	Louis E. Cimino, M.D., Tampa
District 8	
District 9	
District 10	
District 11	
District 12	Tobias R. Funt, M.D., Fort Lauderdale
District 13	
District 14	
District 15	Ronald H. Chase, M.D., Key West

In early February, the county medical society presidents were asked to make nominations for congressional district seats on the Board of Directors. At its meeting on December 17, 1972, the temporary Board of Directors decided to assume responsibility for nominating physicians to district Board seats remaining vacant after February 28, 1973. However, the temporary Board has not exercised this prerogative.

It is hoped that all 15 congressional district Board seats will have been filled by the county medical society presidents prior to the Annual Meeting of the Florida Medical Association.

**By-Laws:** Up to the present time, this Association has been operating within certain organizational and procedural guidelines spelled out in the Articles of Incorporation. By-Laws have been drafted but are not at the present time in force and effect. Consideration of By-Laws will be on the agenda for the first meeting of the FPA Board of Directors.

**American Physicians Guild:** In February, the American Physicians Guild sent a "Dear Florida Medical Colleague" letter to members of the Florida Medical Association. This letter purported to illustrate the differences between the American Physicians Guild and the Florida Physicians Association, Inc. on several points and concluded with an appeal for physicians to join the Guild. Only one member of the Florida Physicians Association is known to have withdrawn from FPA as a result of this letter.

## Judicial Council

The Reference Committee considered the report of the Judicial Council and the Supplemental Report of the Judicial Council and recommended that they be adopted.

They were adopted [with the exception of the matter pertaining to Medical Student Membership, which was referred to the Board of Governors by Reference Committee I].

## Judicial Council

VINCENT P. CORSO, M.D., *Chairman*

Forging a closer relationship with the Florida State Board of Medical Examiners, educating county medical societies as to their responsibilities in ethical and disciplinary matters, and revising the "Criteria for Ethical Contracts" have been among the Judicial Council's major activities since the House of Delegates last met.

In other important activities, your Council has studied and made recommendations regarding membership for medical students in the Florida Medical Association; mediated several disputes involving members of the Florida Medical Association; and rendered several decisions and opinions upon request of the Board of Governors, the Executive Committee, and individual members of the Association.

The past year has seen some of the Council's decisions challenged by organized groups and individual members of FMA. This, of course, is their right. Such protestations are even desirable because they help demonstrate that the Florida Medical Association is an orderly democratic system existing within a larger democratic system.

All who would take issue with our decisions should be aware that this Council never makes quick judgments, especially on those issues with far-reaching implications. On the contrary, considerable research is conducted on the major issues confronting us, and it is not unusual for a particular matter to be discussed at length, then passed over for two or three meetings before judgment is rendered.

In appraising the issues before it, your Council seeks to arrive at decisions that are fair and just. What the Council believes to be fair and just is not always popular. To render only popular decisions would not be in the interest of our profession and would indeed negate any need for a Judicial Council.

Since we last reported to the House of Delegates, your Council has held five meetings. The following is a summary of the activities, decisions and recommendations arising from these meetings:

**Florida State Board of Medical Examiners:** A 1971 amendment to the FMA By-Laws stated that one member of the Judicial Council will be designated to serve as liaison with the Florida State Board of Medical Examiners (BME). Dr. John J. Cheleden, a member of both the Council and the BME, has been performing this function with dedication. In as much as the Council and the BME have parallel responsibilities and common objectives, the two groups and their respective staffs held a joint meeting on Sunday, July 23, 1972, in Miami Beach. Several matters of mutual interest and concern were discussed, and a procedure was worked out for Judicial Council handling of cases that might fall within the purview of the Medical Practice Act. Another Council-BME meeting is planned for July 1, 1973.

**Regional Membership and Discipline Conferences:** At the 1972 Annual Meeting, the House of Delegates authorized the Judicial Council, upon its request, to conduct a Statewide Conference on Medical Ethics and Discipline. The purpose was to acquaint members of the Committee on Membership and Discipline, county medical society officers and grievance committee members, and others with the disciplinary procedures of the Florida Medical Association, and to instruct them as to their role in this important function of organized medicine.

After some additional discussion, it was decided that attendance at such a conference probably would not justify the effort involved in planning the meeting. Subsequently, the Council abandoned the statewide conference approach in favor of a series of regional meetings, each

lasting one-half day and held in conjunction with the regular quarterly meetings of the Council.

The first such conference, held in Miami in December 1972, for Membership and Discipline Committee members and county medical society personnel in a four-county South Florida area, was, in the opinion of the Council, a complete success. The second conference, for physicians in North Florida, was held in Jacksonville on February 25, 1973. Similar conferences are planned this year for September 23 in Tallahassee, and December 9 in Tampa.

The Florida State Board of Medical Examiners has joined us as a co-sponsor of these conferences.

**Osteopathy:** A most significant and important step was taken by the 1972 House of Delegates when it authorized the creation of the Ad Hoc Committee on Liaison with Osteopathy. Your Council is represented on the committee and is receiving reports of deliberations of that body.

The Council reviewed and approved a policy statement on osteopathy submitted by the Osceola County Medical Society under the provisions of FMA Resolution 70-4. Osceola became the twelfth county society to file such a policy statement with the Council.

**Medical Student Membership:** [REFERRED TO BOARD OF GOVERNORS] Pursuant to favorable action by the 1972 House of Delegates, Recommendation No. 10, 1972 Report of the Council on Scientific Activities, relating to FMA membership for medical students, was referred to the Judicial Council for study. In January of this year, your Council communicated its recommendations, including a draft of proposed amendments to the By-Laws to provide for student membership, to the Board of Governors. Generally, this Council favors creation of a special membership category for bona fide medical students; establishment of a student component society at each medical school in Florida; voting representation in the FMA House of Delegates; and eligibility for appointment to committees and Councils. (Referred to Board of Governors—R.C. I)

**Physician Billing Survey:** In mid-1971, the Judicial Council through its Committee on Membership and Discipline, undertook a survey of billing procedures used by hospital-based physicians. The Committee had available from Blue Shield of Florida statistical information relative to billing (separate vs. combined) for services of pathologists, radiologists and physicians who interpret EKG's and EEG's on a hospital-by-hospital basis throughout Florida.

The mission had a two-fold objective: (1) to verify all data provided by Blue Shield; and (2) to encourage physicians on combined billing with their hospitals to convert to separate billing. Much progress was made toward both objectives in most of the congressional districts; little progress was made in others.

On May 3, 1972, the Judicial Council held a special meeting with representatives of the specialties of internal medicine, neurology, pathology, and radiology. In general and in principle, they were in agreement as to the desirability of separate billing.

It was felt at that point that the Council had passed its peak of effectiveness in conducting the billing survey and that the specialty groups themselves or the Council on Specialty Medicine would be the logical groups to carry the canvass to its conclusion. Thus, your Council recommended, and the Board of Governors concurred, that this project be transferred from the Judicial Council to the Council on Specialty Medicine.

**Abortion:** With the passage of abortion reform legislation in Florida in the spring of 1972, your Council was called upon to develop some standards to govern the professional activities of FMA members in view of this act. The Council made the following declaration:

#### "ETHICAL GUIDELINES FOR THE TERMINATION OF PREGNANCIES"

"The Principles of Medical Ethics of the Florida Medical Association and the American Medical

Association do not prohibit a physician from performing an abortion that is performed in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices.

Termination of pregnancy is a medical procedure which must be done strictly in accordance with the highest standards of medical practice. The rights of the patient must be upheld and ethical principles observed just as in any other medical procedure.

The ethical principle remains that no physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him. The Judicial Council strongly condemns any attempt at commercialization of abortion or the establishment of 'abortions mills'.

The Judicial Council strongly recommends that any physicians who participate in the termination of pregnancies familiarize themselves with the 1972 Act of the Florida Legislature on this subject."

**Referrals from PMUR Committee:** During its review of Medicare charges of various physicians, the Committee on Peer Medical Utilization Review has been referring the case of an occasional physician to the Executive Committee and/or Board of Governors for possible further investigation. These have been handed down to the Judicial Council. A policy has been adopted whereby such cases involving non-members of FMA are referred directly to the Florida State Board of Medical Examiners. In the case of FMA members, your Council prefers that the physician's county medical society conduct the inquiry and counsel him in whatever way might be appropriate.

**Denial of Membership in Specialty Group:** An FMA member's complaint that he was denied membership in an FMA-recognized specialty group was referred to the Council by the Executive Committee. Since it appeared to the Council that the aggrieved member met the qualifications for membership in the specialty group, an inquiry was begun. At the next election, the member was admitted, and the Council closed the case.

**Paid Newspaper Announcements:** A crisis was precipitated during the year when a Polk County physician purchased space in an Orlando newspaper (Orange County) to announce the association of another physician in his office. The Orange County Medical Society lodged a protest on the ground that local ethics do not permit a member of the Orange County Medical Society to "advertise" in a newspaper. In its investigation, the Council found: (1) the Polk County physician was not violating the policy of the Polk County Medical Association regarding paid newspaper announcements; and (2) the Orlando newspaper in which the announcement appeared has a substantial circulation in Polk County.

Your Council held that a physician is governed only by the rules of his own county medical society in the matter of newspaper announcements, and thus the Polk County physician had not acted improperly. The judgment was reaffirmed upon reconsideration by request of the Orange County Medical Society.

**Uniform Standards for Newspaper Announcements/Directory Listings:** The Board of Governors has asked the Judicial Council to investigate the possibility of promulgating uniform standards of paid newspaper announcements and yellow page directory listings of physicians to apply to all component societies of FMA. Traditionally, both of these matters have been left to local custom and discretion. In Florida, county medical society policies on both subjects vary greatly. Some are very restrictive; others are very permissive.

Your Council can see considerable merit in having all members of FMA live by the same standard. However, the problem is being approached with extreme caution. A memorandum has been sent to all county medical societies seeking (1) copies of all local policies on newspaper announcements and directory listings; and (2) an expression of opinion as to whether uniform standards should be adopted.



It is expected that a report on this matter will be submitted at the October 1973 meeting of the Board of Governors.

**Office Signs:** A county medical society asked the Council what should be the maximum size of lettering on signs outside physicians' offices. State law requires doctors of medicine and all other "practitioners of the healing arts" to post their names and degree (M.D., D.O., etc.) in lettering no smaller than 2½ inches in height and one inch in width at the entrance to their offices. However, the law does not specify a maximum size for the lettering. The Council believes that this is a matter best left to the judgment of the county medical society.

**Martin County Medical Society (Proposed):** The Council has received a petition signed by 31 physicians residing and/or practicing in Martin County, Florida, seeking FMA sanction of a new Martin County Medical Society. The President of the existing St. Lucie-Okeechobee-Martin County Medical Society stated that his Society has no objection to the separation of the Martin County group. The Council is recommending to the Martin County group that certain relatively minor changes be made in its By-Laws as submitted.

## RECOMMENDATION

That the House of Delegates officially recognize the Martin County Medical Society as a component of the Florida Medical Association; that a Charter be granted to the Martin County Medical Society; and that the existing St. Lucie-Okeechobee-Martin County Medical Society be rechartered to reflect the removal of Martin County from its area of jurisdiction.

**Criteria for Ethical Contracts:** Over a period of several months, the Council became aware of certain problems arising from the Florida Medical Association's "Criteria for Ethical Contracts Between Physicians and Hospitals." Some small community hospitals, apparently under local pressure to provide better emergency room coverage, reported difficulty in drafting agreements satisfactory both to the physicians and to the hospitals themselves and at the same time meeting FMA's criteria. The proscription against "minimum" or "guaranteed" income was often mentioned as a difficulty. Some hospitals felt that in order to attract and keep one or more emergency room physicians, some sort of guarantee or subsidy would be necessary.

In October 1972, this Council submitted to the Board of Governors a revised "Criteria for Ethical Contracts Between Physicians and Hospitals." Prohibitions against "minimum" or "guarantee" were eliminated in the revision, which was approved by the Board.

Your Council believes that the revised criteria will facilitate contracting between physicians and especially the smaller hospitals. No basic principles have been sacrificed. Your Council remains unalterably opposed to corporate medical practice or any contractual arrangement that relegates nongovernment FMA members to the role of hourly-paid employee or pawn of his hospital.

**Health Maintenance Organizations:** Your Council is aware of the development of Health Maintenance Organizations (HMO's) in the State of Florida, particularly the Florida Health Care Plan, Inc., of Daytona Beach. The declaration of Opinion 71-4 (Health Maintenance Organizations) was reported to the 1972 House of Delegates.

Various questions about HMO's have been received. In response, the Council has held that: (1) the fact that a physician is associated with an HMO should not be a determining factor at such time as a county medical society acts upon his application for membership in that society and the FMA; and (2) a physician on emergency call at a hospital should treat all patients consistent with

the rules of the hospital, and in the matter of payment for these services, an HMO should be regarded in the same way as any other third party.

**Opinion 72-2 (Solicitation of Patients by Physician Controlled HMO's):** The Board of Governors asked the Council to render an opinion as to whether it is proper for physician controlled Health Maintenance Organizations to solicit patients:

### OPINION 72-2 (SOLICITATION OF PATIENTS BY PHYSICIAN CONTROLLED HMO'S)

... The Council regards Health Maintenance Organizations as a type of pre-paid health care plan, a third party to the doctor-patient relationship. It must be recognized that any such plan, if it is to compete in the marketplace and survive, will be promoted and sold to subscribers. A physician who has any connection whatever with a Health Maintenance Organization should take all reasonable steps at his disposal to prevent the use of his name, either directly or indirectly, in a manner which might influence the decision of any individual or group of individuals to subscribe to the services of the HMO.

**Reporting Disciplinary Actions:** It is important that proper communications be maintained when the Florida State Board of Medical Examiners or a county medical society takes disciplinary action against an FMA member. The BME customarily reports all license suspensions, revocations, warnings, probations, etc., to the FMA headquarters, and these notices are forwarded to the proper county medical societies.

In return, the BME wishes to be advised, through the FMA, whenever a county society disciplines a member. Your Council feels that this is important and has recommended to the Board of Governors that county societies be urged to include in their By-Laws at the earliest possible date provisions for reporting disciplinary actions against members to the FMA, thence to the Board of Medical Examiners.

**Opinion 72-1 (Employment of Anesthetists by M.D.'s):** The Council was asked to rule in a situation in which a group of anesthesiologists employed a non-M.D. anesthetist and charged their usual and customary fee for his services. After prolonged study and contemplation, the Council rendered a formal opinion, which perhaps was too specific for general application. Upon request, the Council reviewed its opinion and amended it as follows:

### OPINION 72-1 (AMENDED) (EMPLOYMENT OF ANESTHETISTS BY M.D.'S)

... Anesthesiology is a practice of medicine. In the opinion of the Council, it is ethical for an anesthesiologist to employ a properly trained non-physician anesthetist. The patient and the surgeon must be fully informed that the non-physician anesthetist will be giving the anesthesia. The anesthesia fee should be commensurate with the services rendered.

**Physician Recruitment:** It has become rather common practice for county medical societies and other community groups to conduct physician recruitment programs during examination sessions of the Florida State Board of Medical Examiners. While these groups are to be commended for their activities toward attracting additional physicians for their communities, aggressive campaigns of this nature can lead to excesses and unfortunate situations.

As an example, during the July 1972 meeting of the BME at Miami Beach, a display advertisement appeared in the Miami Herald addressed to physicians who were there to take the examination and listing the names of leaders of one Florida community, including two members of the Florida Medical Association. The advertisement listed a high income that physicians who wish to



locate in the community could expect to earn, and was, in the judgment of the Council, misleading and detrimental to the medical profession. The Council called the attention of the two physicians whose names appeared in the advertisement to the impropriety of the ad. The Council is satisfied that in this instance the two physicians were not aware that their names were to be used in this fashion; however, each county medical society should take whatever steps are necessary to guard against recurrences.

The Council is exploring with the Board of Medical Examiners some system by which the names of all examination applicants could be supplied to county medical societies, thus rendering such advertisements totally unnecessary.

**FMA Advertising Policy:** The Council has had under study apparent inequities related to the ethics and policies of advertising in *The Journal of the Florida Medical Association*. Existing policy allows *The Journal* to accept advertising from lay laboratories, provided the testing is done under medical supervision and no interpretation of test results is rendered.

These laboratories, of course, operate in competition with pathologist-owned laboratories and individual pathologists who, as physicians, are not permitted to advertise. The situation is further complicated by the fact that for many years *The Journal* and other scientific publications have accepted advertising from psychiatric hospitals, alcoholic rehabilitation centers and related facilities which lists members of the professional staff.

A thorough study is being made, and during the next year, the Council hopes to be able to suggest a solution.

**Itemized Bills:** From time to time, a question arises with respect to a physician's responsibility to render an itemized bill upon request by a patient. During the past year, your Council was asked if a physician may require the patient to pay his fee in full before he renders an itemized statement. The Council's answer was: "A physician should not require a patient to pay the bill in full before rendering an itemized bill unless there is a clear understanding before treatment begins."

**Opinion 71-5 (Assistant Surgeon Fees):** The Council's Opinion 71-5 (Assistant Surgeon Fees) was reported to the House of Delegates in 1972 and was published in the July 1972 issue of *The Journal of the Florida Medical Association*. However, during the past year the Council amended Opinion 71-5 as follows:

#### OPINION 71-5 (AMENDED) (ASSISTANT SURGEON FEES)

... A surgeon may use his office associate as his assistant in surgery, but the associate is entitled to a fee only for procedures wherein the hospital rules and regulations require an assistant in the operating room. It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance. In both circumstances, the patient must be provided with a bill itemizing both the surgeon's and the assistant's fees.

**Otolaryngologists/Otologists:** A county medical society asked the Council about the propriety of a group of otolaryngologists "associating with an otologist (not M.D.) and the prescribing and supplying of hearing aids by the doctors and this associate." The Council held that such an association is not unethical, provided that the non-M.D. otologist is an employee of the doctors and not a partner or associate, and provided that patients are made aware of the fact that he is not a doctor of medicine.

**Cardiac & Pulmonary Rehabilitation Centers:** The Council was contacted by a representative of Cardiac and Pulmonary Rehabilitation Centers of Mechanicsburg, Pa., which plans to establish one or more facilities in Florida for the rehabilitation of cardiac patients. C&PRC sought ethical clearance from the Judicial Council. It is the judgment of the Council that C&PRC seeks to

provide a service for which there is a definite need. Based on written information submitted by C&PRC and on a personal interview with Philip K. Hensel, M.D., an official of the Centers, the Council could perceive no unethical aspects of the proposed centers. However, the Council feels that the approval of the appropriate county medical society should be obtained before each center is established.

**Grievances and Complaints:** During the year a number of complaints were received from the general public against members of the Florida Medical Association. These were referred to the appropriate county medical society grievance committee, and most were investigated and resolved within a reasonable time. Some cases were appealed to the Judicial Council. In all such instances, the Grievance Chairman of the Council conducted his own review and reported his findings to the entire Council. At the present time, the Council has no patient/physician grievances before it on appeal.

**Membership and Discipline Committee:** The Membership and Discipline Committee carried out several investigations for the Council as well as for the Florida State Board of Medical Examiners. Council projects included a case in which a physician had been dismissed from the medical staff of a hospital in Brevard County; a dispute involving three members of the Lake County Medical Society; and a controversy in Washington County involving the hospital and physicians there.

## Supplemental Report Judicial Council

The Leon-Wakulla-Jefferson County Medical Society was surveyed at its request recently by a team from the American Medical Association. The survey team recommended, among other things, that the Society consider a new name for itself.

Jack W. MacDonald, M.D., President of the Society, has advised the Florida Medical Association that the general membership of the Society has adopted a motion of intent to adopt the name "Capital Medical Society."

The Judicial Council was polled by telephone, and it is in agreement with the intentions of the Leon-Wakulla-Jefferson County Medical Society.

### RECOMMENDATION

It is recommended that the Leon-Wakulla-Jefferson County Medical Society be rechartered as the "Capital Medical Society."

#### Council on Special Activities

Upon recommendation of the Reference Committee the report of the Council on Special Activities was adopted as presented.

#### Supplemental Report Committee on Archives

Upon recommendation of the Reference Committee, the Supplemental Report of the Committee on Archives was adopted as presented.

## Council on Special Activities

HENRY J. BABERS JR., M.D., *Chairman*

The Council has continued its function of coordination of Association archives and activities of the Board of Past Presidents.

The Committee on Archives has assessed its role, activities and accomplishments since its inception. In the beginning the committee concerned itself mainly with collecting obituary information on deceased members.

During 1960-1966, the committee conducted an all-out campaign to obtain biographical data on all members of the Florida Medical Association. It constructed the "Data for Archives" Form, which was in time supplied to all members with a request it be returned. Older members responded best, with an approximate 75%-80% return. The younger group (under age 60) responded less well, and under 40 was almost a futile effort. The By-Laws were amended to require this information of all new members in 1965; however, those members "grandfathered" at the time of this amendment simply never sent it. Further efforts to obtain the missing Data for Archives were fruitless, and in 1967, the Committee discontinued further efforts along this line.

In 1965, the tradition of honoring groups of members according to year joined was instituted. This was well received at the beginning, and a short reception was held during the annual meeting for them, along with special ribbons on convention badges and recognition during the House of Delegates. Attendance among this group and participation in the reception was well above 50% of the eligible group. However, as the group being honored became larger and more recent, response lessened. In 1973, only two members among a group of almost 100 honorees attended the annual meeting. (At least, only two called for their badges.) The last reception scheduled had a very poor attendance, and prompted the decision of the committee to change to an every-five-year function.

Other activities of the committee have included a Memorial Service held annually at the first meeting of the House for members who died during the past year, placement of historical markers around the state at appropriate sites, compilation of information for a history of medicine in Florida, the History of Medicine Museum in St. Augustine, and the August Historical Issue of the FMA Journal.

The FMA has recently converted its membership records to the CAPIS program (Central Automated Physicians Information Service). Through this system, access is available to biographical data on all M.D.'s in the U.S., and when a physician joins FMA, this information is promptly supplied to the FMA office on an individual form for that physician.

The Annual Meeting is crammed with meetings, and time and space during this five-day period is at an absolute premium. Members are busy and there is almost no way to hold a reception at a time when some urgent meeting is not going on. Ribbon streamers are expensive, and it is a very time consuming and expensive task to plan this, considering the small response.

## RECOMMENDATIONS

1. That the function of obtaining biographical information on members for Association archives be made an administrative responsibility, to be handled by staff in the executive office.
2. That problems of membership be referred when necessary to the Judicial Council for consideration by the Committee on Membership and Discipline.
3. That the tradition of honoring groups of members with ribbon streamers and reception be discontinued, due to the lack of interest.
4. That the Committee on Archives be abolished and in its place an office of Historian be created, whose duties would include the memorial services at the House of

Delegates, historical marker placing as appropriate, consultation with the Editor for publication of the historical issues of the Journal, liaison with groups involved in completing the History of Medicine Museum in St. Augustine, and the history of medicine in Florida in general.

The Board of Past Presidents met for its annual breakfast meeting during the 1972 annual meeting with 17 past presidents in attendance. The Board was reminded of the past president's fund in the Florida Medical Foundation for indigent doctors. Many of the past presidents continue to be active in the affairs of their county societies and of FMA, and are available to assist wherever possible.

## Supplemental Report Committee on Archives

The Association has lost a number of its fine members during the past year and a list of their names is given below.

- 1965  
Douglass, Lawton F.—Polk
- 1967  
Farber, William P.—Pinellas
- May 1969  
Black, John B.—Duval
- March 1970  
Connor, Arthur B.—Broward  
Morgan, Thomas E.—Nassau
- February 1971  
Bekey, William E.—Dade
- May 1971  
Hoover, George W.—Broward  
Roberts, Samuel J.—Dade
- July 1971  
Wilhoite, Roy E.—Polk
- August 1971  
Bottari, Giulio C.—Hillsborough
- November 1971  
Farnell, Croley M.—Suwannee-Hamilton-Lafayette  
Jensen, Jacob R.—Orange
- December 1971  
Bolton, Patricia O.—Broward
- March 1972  
Friend, LeRoy F.—Volusia
- April 1972  
Brown, Harry W.—Pinellas  
Cunningham, Charles B.—Pinellas  
Howard, Roland F. Sr.—Orange  
Rogers, W. W.—Duval  
Weiss, Jason—Broward
- May 1972  
Adams, Samuel H.—Hillsborough  
Bransford, Lee E. Sr.—Duval  
Clardy, Ed Rucker—Marion  
McLemore, Carl S.—Orange  
Murphy, Ralph D.—Pinellas  
Payne, Walter C. Sr.—Escambia  
Scott, Douglas G.—Duval
- June 1972  
Dame, Leland H.—Orange  
Dicks, Reid E.—Pinellas  
Langley, Francis H.—Pinellas  
Pavlin, Otto B.—Manatee
- July 1972  
Hinton, Andrew H.—Dade  
Larson, Eli—Dade  
Levin, Leo M.—Dade  
Shaar, Richard T.—Duval  
Stone, Vale D.—Palm Beach  
Thomas, William C. Sr.—Alachua



#### August 1972

Astler, DeWitt G.—Orange  
Barry, Andrew J.—Alachua  
Evans, Willis F.—Escambia  
Knowles, Harold S.—Orange  
Korus, Hanns C.—Volusia  
Zarzecki, Casimer A.—Dade

#### September 1972

Grunnagle, Jerome F.—Collier  
Meador, Murray W.—Dade  
Palacio, Guillermo R.—Palm Beach  
Shoelson, Seymour M.—Dade  
Simendinger, Earl A.—Hillsborough

#### October 1972

Barge, Hubert A.—Dade  
Cumming, Richard C.—Marion  
Deen, Oliver F. Jr.—Hillsborough  
Eisenman, Leon S.—Dade  
Lewis, Alfred L. Jr.—Leon-Wakulla-Jefferson  
Murphy, Alvin E.—Palm Beach  
Pierce, LeRoy C.—Hillsborough  
Robson, Frank Y.—Pasco-Hernando-Citrus

#### November 1972

Beamer, William D.—Osceola  
Hutchins, Paul F.—Duval  
Snyder, John W.—Dade

#### December 1972

Eckmeyer, Ernest W.—Leon-Wakulla-Jefferson  
Lageyre, Guillermo—Dade  
Moss, Jack W.—Pasco-Hernando-Citrus  
Weil, Nathan Jr.—Duval

#### January 1973

Miller, Redden L.—Panhandle  
Peek, Cecil M.—Palm Beach  
Pilliod, John V.—Lee  
Smith, William K.—Lake  
Zeagler, George M.—Putnam

#### February 1973

Brookins, James O.—Hillsborough  
Fanelli, Mary Jo—Pinellas  
Hardee, Erasmus B. Sr.—Indian River  
Judd, Allyn F.—Palm Beach  
Stoddard, Guy R.—Dade

#### March 1973

Dann, Thomasson P.—Pinellas  
White, Charles M.—Dade

#### April 1973

Waite, Ellsworth F.

### Resolution 73-4 Osteopathic Physicians Lee County Medical Society

The Reference Committee recommended that Resolution 73-4 be referred to the Board of Governors for continued study and further consideration by the Ad Hoc Committee on Liaison with Osteopathy because, at the present time, the legal problems cannot be worked out until a composite M.D./D.O. Board of Medical Examiners is established.

A substitute motion was made from the floor that the resolution be adopted with an amendment deleting the RESOLVED referring to the State Board of Medical Examiners. The motion was ruled out of order, there was discussion, and the House voted on the recommendation of the Reference Committee.

The motion to refer failed to carry.

A motion was made to table the resolution. The motion carried, and Resolution 73-4 was tabled.

### Resolution 73-5 Criteria for Recognition of Specialty Groups Franklin B. McKechnie, Delegate J. Gerard Converse, Delegate

The Reference Committee noted, through information presented during the Reference Committee hearing, the AMA Board of Trustees' action that approved membership criteria for the Interspecialty Council requires that an applying specialty society be in existence for at least five years and have 60% membership in the AMA, as was stated in the *AMA Newsletter*, Volume 5, Number 10, dated March 12, 1973; however, it is the consensus of the Reference Committee that Resolution 73-5 is out of order, since it proposes an action which would require a change in the By-Laws and which is not under consideration by this House at the present time. The Reference Committee recommended that the Board should consider this resolution again and take whatever action it deems necessary.

The Chair concurred with the opinion of the Reference Committee that the resolution is out of order and the subject of a By-Laws change is not before the House at this time. The ruling of the Chair was challenged, upon a vote of the House the ruling was upheld, and Resolution 73-5 was declared not under consideration.

### Resolution 73-10 Two Board of Medical Examiners Dade County Medical Association

The Reference Committee recommended that Resolution 73-10 not be adopted, because it was declared that by the expansion of the Board of Medical Examiners, the results proposed in Resolution 73-10 could be better obtained.

Resolution 73-10 was not adopted.

### Resolution 73-15 AMA Councils Everett Shocket, Delegate

The Reference Committee considered Resolution 73-15 and recommended that in view of the manner in which the resolution is written, and due to a report given by an AMA delegate at the Reference Committee hearing, it no longer applies to the situation and should be filed.

It was filed.



**Resolution 73-19**  
**Statewide Uniform Ethical Standards**  
**Orange County Medical Society**

The Reference Committee considered Resolution 73-19 and, upon the request of Dr. Franklin B. McKechnie, representing Orange County Medical Society, recommended amendments to delete "therefore, be it further" in the first "RESOLVED" and to delete the entire last paragraph which is the last "RESOLVED." The Reference Committee called attention to the fact that the matter of Statewide Uniform Ethical Standards has already been discussed by the Board of Governors and referred to the Judicial Council, who is currently making a study into the problem.

Upon recommendation of the Reference Committee, the resolution was adopted as amended.

**Resolution 73-19**

**Statewide Uniform Ethical Standards**

RESOLVED, That the Florida Medical Association refer the resolution pertaining to statewide uniform ethical standards to the appropriate committee for study and recommendation.

**Resolution 73-23**  
**Community Health Care Projects**  
**Pinellas County Medical Society**

The Reference Committee that Resolution 73-23 be adopted.

A motion was made from the floor to amend the resolution by adding, "and notification to be sent to all appropriate agencies and societies such as federal, state, city and county governments and all voluntary health agencies and societies." The motion was seconded, the amendment was adopted, and Resolution 73-23 was adopted as amended.

**Resolution 73-23**

**Community Health Care Projects**

RESOLVED, If a project or proposal related to health or health care delivery in a community is being considered, notification of the county medical society be achieved to include not only the officers of the society but also the membership, as early in the planning stage as is feasible and practical; be it further



Dr. Dean presents Dr. William M. Straight the Certificate of Appreciation for exceptionally meritorious service to the Association.

RESOLVED, That when possible and applicable, approval of the county medical society be achieved either through its membership or its Board of Directors prior to commencement of the project or proposal; and be it further

RESOLVED, That any other communities or medical societies that may also be affected by such project or proposal be likewise notified and notification to be sent to all appropriate agencies and societies such as federal, state, city and county governments and all voluntary health agencies and societies.

The Report of Reference Committee No. III was adopted as amended.

Dr. Dubose: "Mr. Speaker, this concludes the report of Reference Committee No. III."

### Certificate of Appreciation

The Speaker called for Dr. William M. Straight to come to the podium. Dr. Straight was presented the Certificate of Appreciation.

Dr. Straight: "Gentlemen, I thank you for this kind honor you have given me. Indeed, it is frosting on the cake when you are honored for something you enjoy doing. Thank you."

### Certificate of Appreciation

Whereas, William Marcellus Straight, M.D., of Miami, has been instrumental in preserving Florida's rich medical heritage through his writings and teachings; and

Whereas, Dr. Straight was born in the City of Philadelphia but adopted Florida as his home many years ago; and

Whereas, He received a Bachelor of Science degree in chemistry from the University of Florida in 1940, and

a Doctor of Medicine degree from Johns Hopkins Medical School in 1943; and

Whereas, He chose to study the specialty of internal medicine and particularly cardiology; and

Whereas, The diploma of the American Board of Internal Medicine was awarded to him 21 years ago; and

Whereas, On the national level, he is member of the American Society of Internal Medicine and the American Association for History of Medicine, and a Fellow of the American College of Cardiology and the American College of Physicians; and

Whereas, Dr. Straight has served the Florida Society of Internal Medicine as its President and the Dade County Medical Association as its President and in many important committee assignments; and

Whereas, He has served the Florida Medical Association as Chairman of the Committee on Archives, Member of the Judicial Council, and Associate Editor of *The Journal of the Florida Medical Association*; and

Whereas, This esteemed physician holds faculty positions as Associate Professor of Medicine and Instructor in the History of Medicine at the University of Miami School of Medicine; and

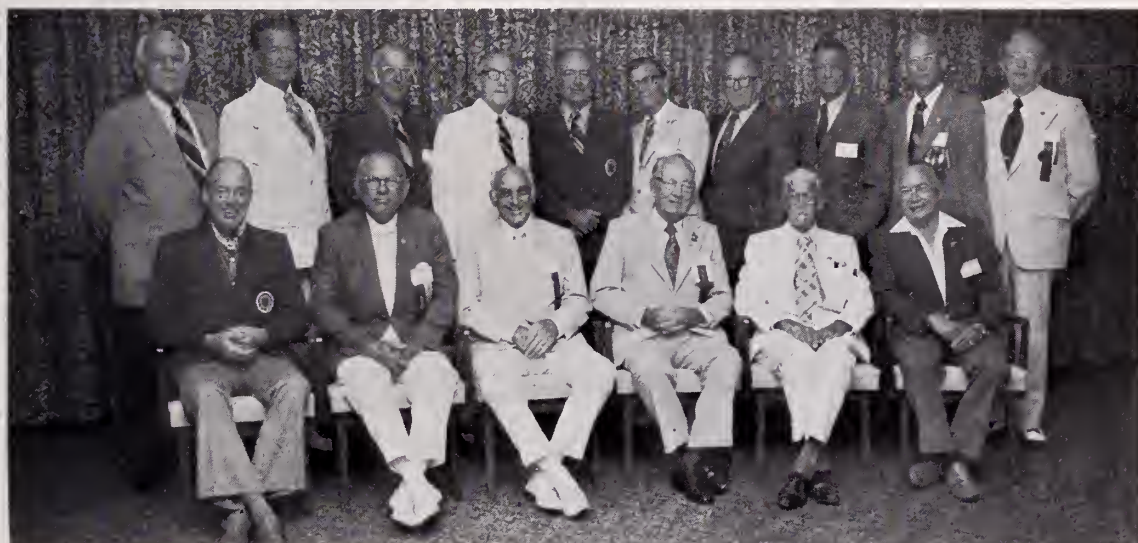
Whereas, Since 1965, Dr. Straight has played the leading role in the writing and compiling of papers for the annual Historical Issue of *The Journal of the Florida Medical Association*, which no doubt will serve as a valuable reference for future medical historians; and

Whereas, Dr. Straight is and has been hard at work planning and preparing for the Centennial Issue of *The Journal of the Florida Medical Association*, which will be published in 1974 as the Florida Medical Association approaches its 100th anniversary, therefore be it

RESOLVED, That this Certificate of Appreciation, established in 1961 for the purpose of acknowledging exceptionally meritorious service, be awarded to WILLIAM MARCELLUS STRAIGHT, M.D., in recognition of his many contributions to the medical profession in Florida and to the preservation of its history.

The Speaker announced that the House would recess until Sunday morning at 9:00 a.m.

The Second Meeting of the House of Delegates recessed at 5:10 p.m.



All of these men have served as president of FMA and attended a breakfast in their honor at the annual meeting. They are: (front row) Samuel M. Day, M.D., Jacksonville; William C. Roberts, M.D., Panama City; John D. Milton, M.D., Coral Gables; Walter C. Jones, M.D., Miami; Joseph S. Stewart, M.D., Miami; Jere W. Annis, M.D., Lakeland. Back row: Jack Q. Cleveland, M.D., Coral Gables; H. Philip Hampton, M.D., Tampa; W. Dean Steward, M.D., Orlando; George S. Palmer, M.D., Tallahassee; James T. Cook, M.D., Marianna; Floyd K. Hurt, M.D., Jacksonville; Henry J. Babers, M.D., Gainesville; Warren W. Quillian, M.D., Coral Gables; Robert E. Zellner, M.D., Orlando and Leo M. Wachtel, M.D., Jacksonville.





The Association's photographer took these candid shots during the annual meeting: (Upper left) Dr. William J. Dean, Mrs. Dean, W. Harold Parham, Mrs. Von Thron and Dr. Joseph C. Von Thron. Dr. and Mrs. Henry Babers greet Dr. M. C. Wilhoit, Dr. and Mrs. Russell B. Roth of Erie, Pa. Dr. and Mrs. Jere W. Annis greet Dr. and Mrs. Von Thron, Dr. and Mrs. W. Dean Steward, Mrs. Von Thron and Mrs. James J. DeVito, Dr. and Mrs. Von Thron pose with their children, Jim, Judy, Joan and John.





(Upper left) Dr. and Mrs. William J. Dean; Dr. and Mrs. James J. DeVito, and Dr. and Mrs. Joseph C. Von Thron. Senator John Tower of Texas; Mrs. Robert F. Beckley, President WA/AMA and Dr. Russell Roth. Mrs. Clyde M. Collins and Dr. B. J. Philips, Dr. and Mrs. W. H. Mathews. Dr. and Mrs. Dean with their daughter, Julia and son, Bryson.

# Third House of Delegates

The third meeting of the House of Delegates convened at 9:07 a.m. on Sunday, May 13, 1973, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

Dr. Nikolaus, Chairman of the Credentials Committee, reported 186 delegates registered constituting a quorum, and moved that the House be seated. The motion carried.

## Delegates

ALACHUA—Allen Y. DeLaney, David M. Drylie, Charles H. Gilliland, George W. Little, George H. Miller Jr., Gerold L. Schiebler.

BAY—(Absent—James Phillips, W. C. Roberts).

BREVARD—John T. Blackburn, Michael J. Foley, Edwin E. Hadden Jr., T. John Kaminski, Robert C. Seelman.

BROWARD—Miles J. Bielek, Andre S. Capi, Yale Citrin, Richard S. Doyle, Joseph E. Gelety, Ray E. Murphy Jr., Frank B. Ott, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Dan C. Smith, John I. Williams (Absent—Russell B. Carson, Milton P. Caster, Leonard A. Erdman, F. Gary Gieseke, John R. Mahoney).

CHARLOTTE—Melvyn J. Katzen.

CLAY—Laurin G. Smith III.

COLLIER—Foster L. Bullard Jr., Hoke H. Shirley Jr.

COLUMBIA—John T. Wilson.

DADE—Jerome Benson, Rufus K. Broadaway, Harvey E. Brown Jr., Manuel L. Carbonell, Richard C. Clay, Jack Q. Cleveland, A. J. Fernandez Conde, Francis N. Cooke, Vincent J. Corso, Edward W. Cullipher, Dewitt C. Daughtry, O. William Davenport, Joseph H. Davis, Richard C. Dever, Robert F. Dickey, J. Lee Dockery, Miguel Figueroa Jr., Richard M. Fleming, M. Eugene Flipse, Marshall F. Hall, Henry C. Hardin, Joseph Harris, James J. Hutson, Walter C. Jones III, Maurice H. Laszlo, Carlos G. Llanes, Rose E. P. London, Seymour B. London, Ronald J. Mann, Ildefonso R. Mas, Bruce E. Miller, John D. Milton, Charles A. Monnin, Sheldon D. Munach, Jorge R. Pena, Julian A. Rickles, Ronald H. Scherr, Janice K. Sherwood, Everett Shocket, William M. Straight, Charles F. Tate Jr., Maynard F. Taylor, Elliott Witkind, Arthur W. Wood Jr., Scheffel H. Wright, Sheldon Zane (Absent—John O. Brown, Charles A. Dunn, Edward W. St. Mary, Robert E. Willner).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Warren M. Barrett, James L. Borland Jr., Yank D. Coble Jr., Clyde M. Collins, Emmet F. Ferguson Jr., Stephen P. Gyland, Millard F. Jones, Leonard E. Masters, Charles B. McIntosh, Faris S. Monsour Jr., Thad M. Moseley, Sanford A. Mullen, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander.

ESCAMBIA—Charles J. Kahn, Theodore J. Marshall, Philip B. Phillips, William M. C. Wilhoit (Absent—F. Norman Vickers).

FRANKLIN-GULF—Joseph P. Hendrix.

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Irving M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Richard S. Hodes, Thomas E. McKell, W. Mahon Myers, Curtis G. Rorebeck, William W. Trice, Harold L. Williamson.

INDIAN RIVER—J. C. Robertson, Daniel Thornton.

LAKE—Fred C. Andrews, Thomas D. Weaver.

LEE—Larry P. Garrett, J. Stewart Ragen III, F. Lee Howington.

LEON-WAKULLA-JEFFERSON — Edward G. Haskell Jr., Nelson H. Kraeft, Robert N. Webster.

MADISON—(Absent—Johnson Bibb).

MANATEE—John D. Lehman, Roger A. Meyer, Millard P. Quillian.

MARION—Henry L. Harrell, C. Brooks Henderson.

MONROE—Ronald H. Chase.

NASSAU—Marshall E. Groover.

OKALOOSA—(Absent—William W. Thompson).

ORANGE—Norman F. Coulter, Edward L. Farrar, Eugene N. Forrester, Clifford L. Garrard Jr., Paul C. Harding, M. Herbert Martin Jr., Franklin B. McKechnie, Franklin G. Norris, James F. Richards Jr., Edward W. Stone, Thomas B. Thames (Absent—Joseph G. Matthews).

OSCEOLA—George A. Gant.

PALM BEACH—Willard F. Ande, Carl E. Andrews, Vernon B. Asler, Curtis W. Cannon, James F. Cooney, Terry F. Cox, George L. Ford Jr., J. Russell Forlaw, Bernard Kimmel, Richard B. Moore, Dick L. Van Eldik.

PANHANDLE—William F. Brunner.

PASCO-HERNANDO-CITRUS—James P. Gills Jr., Randall W. Jenkins.

PINELLAS—Charles K. Donegan, James C. Fleming, Walter W. Hamilton, Daniel S. Hellman, Roger A. Lauehlin, Jack A. MacCris, William G. Mason, Walter S. McKeithen Jr., James H. Miller Jr., Donald G. Nikolaus, David T. Overbey, Thomas M. Quehl, Rowland E. Wood.

POLK—Marvin G. Burdette, J. Gerard Converse, Howard M. Dubose, John W. Glotfelty, Willard E. Manry, Frank Zeller Jr.

PUTNAM—Roy E. Campbell.

ST. JOHNS—W. W. O'Connell.

ST. LUCIE-OKEECHOBEE-MARTIN—Howard C. McDermid, John F. Powers.

SANTA ROSA—(Absent—Claude J. Barnes).

SARASOTA—John N. Carlson, George M. Coggan, F. H. Pfeifferberger, Karl R. Rolls, Robert E. Windom.

SEMINOLE—Luis Perez.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent—Hugo F. Sotolongo).

TAYLOR—John A. Dyal.

VOLUSIA—Octavius B. Bonner Jr., William E. Carter, Charles A. Stump (Absent—Thomas W. Ayres).

WALTON—(Absent—Howard F. Currie).

SPEAKER OF THE HOUSE—Franklin J. Evans.

VICE SPEAKER OF THE HOUSE—Louis C. Murray.

The Speaker recognized distinguished guests present from allied professions: Evelyn J. Lewis, R.D., Florida Dietetic Association; Sadie Reading, R.N., President, Florida Nurses Association; Chuck Mitchell, Florida Society of Radiologic



Technologists; and Vera M. Barnes, L.P.N., President, Licensed Practical Nurses Association of Florida.

Dr. Francis N. Cooke, Chairman, Committee on Golf, announced the winners of the Golf tournament:

Low Gross Division:

Champion—Dr. Jerry F. Cox, Boynton Beach

Runner-up—Dr. Truxton L. Jackson, Miami

Low Net Division:

Champion—Dr. James R. Hanson, Mount Dora  
Runner-up—Dr. Curtis Rorebeck, Tampa

The Speaker announced that the trophies would be presented at a later date, as they were not available at this time.

The Chairmen of the Committee on Tennis and Committee on Fishing were not present to announce the winners of these tournaments.



Physicians listening attentively to the panel on PSRO are (left to right): Robert T. Rengarts, M.D., Sebring; William M. Straight, M.D., Miami; Samuel W. Page, M.D., Key Largo; W. Dean Steward M.D., Orlando, and Michael J. Pickering, M.D., Lakeland.



# Report of Reference Committee No. IV

## Legislation and Miscellaneous

The Vice Speaker, Dr. Murray, assumed the Chair and called for the report of Reference Committee No. IV, Legislation and Miscellaneous.

Dr. Frank C. Coleman, Chairman, came forward to present the report of Reference Committee No. IV.

### Council on Legislation And Public Agencies

In reviewing the report of the Council, the Reference Committee noted the activities of the Committee on National Legislation and the key contact physicians and commended them for the excellent relationship that has been developed with each member of the Florida Delegation in the U.S. Senate and the U.S. House of Representatives, including the annual congressional visit to Washington to meet with them.

The Committee commended the key contact physicians of each county who worked so effectively with the members of the Florida Senate and the Florida House of Representatives.

The Reference Committee noted particularly the excellent response by the "Physicians of the Day" and commended them for their participation in this program. The Committee also noted the Legislative Bulletin which is published every

week during the Legislative session as well as periodically between sessions, noting that the Bulletin is very informative to the members of the Florida Medical Association and encouraging its continuation.

Upon recommendation of the Reference Committee, it was directed that the Report of the Council on Legislation and Public Agencies be filed and published in the Proceedings.

### Council on Legislation and Public Agencies

SANFORD A. MULLEN, M.D., *Chairman*

Most of the work of the Council on Legislation and Public Agencies is accomplished through the activities of its three committees: Committee on State Legislation, Committee on National Legislation, and Committee on Government Programs. The report of your Council is submitted as the individual reports of the three major committees.

**Committee on National Legislation**—This committee consists of the key contact physicians for each member of the Florida Delegation in the U.S. Senate and the U.S. House of Representatives.

Members of this committee have kept in close touch with their assigned Senators and Congressmen on national legislative matters of interest to FMA and the American Medical Association.



Frank C. Coleman, M.D., Tampa (standing at the podium) was Chairman of Reference Committee IV. His Committee included (left to right): John A. Rush Jr., M.D., Jacksonville; Curtis W. Cannon, M.D., West Palm Beach; (standing and not on the committee—Sanford A. Mullen, M.D., Jacksonville); Charles A. Monnin, M.D., Miami, and Henry L. Harrell, M.D., Ocala. Mrs. Mary Ann Brown served as secretary to the Committee.

A highlight of the committee's activities was the annual congressional visitation which was held in March in conjunction with the Annual AMA-AMPAC Public Affairs Workshop in Washington, D.C.

The committee is actively working to establish a contact physician in each county medical society who can serve as liaison for all activities of the FMA and AMA with regard to the issue of national health insurance. Principal efforts with regard to the national health insurance issues have been confined primarily to educating individual physicians and county medical societies concerning the various proposals that have been introduced in Congress. It is anticipated that during the latter part of 1973, a program will be undertaken to develop a greater public awareness of the facts concerning this most significant issue.

**Committee on State Legislation**—The committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized medical specialty groups. Three formal meetings of the committee have been held along with many informal conferences among committee members as items of an urgency nature arose. The committee is particularly pleased with the results of the Legislative Seminar, which was held as a part of the annual FMA Leadership Conference in Orlando, January 28, 1973.

Consistent with the policies developed by the FMA House of Delegates, the committee has worked closely with the Board of Governors in developing a legislative program for the 1973 Session of the Florida Legislature.

The following items summarize the committee's activities:

1. **Capital Office**—The Capital Office has continued to function under the supervision of Mr. Donald S. Fraser, Jr., Director of the Public Affairs Department of the FMA. Additional part-time assistance was used while the Legislature was in session, not only to assist in the operation of the Capital Office, but to provide close liaison with the physician serving as "Doctor of the Day". Increased emphasis was placed on using the resources of the Capital Office to provide better service and coordination for the various medical specialty groups.

2. **The Capitol Dispensary**—The committee has continued to place major emphasis on working with the Capitol Dispensary, which has proved to be most important in meeting the medical needs of legislators and their staffs. The critical shortage of space in the dispensary has been partially alleviated by the addition of another room. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the dispensary with the "Doctor of the Day" program.

3. **Key Contact Physicians**—The committee on State Legislation has continued to emphasize the need to develop a good key contact physician program in each county medical society in the state. This program continues to be the cornerstone upon which a successful legislative program is built.

4. **Publications**—The Legislative Bulletin was published every week during the legislative session and periodically between sessions. The Bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A pamphlet entitled "FMA Legislative Objectives—1973" was prepared by the committee, primarily for distribution to members of the Florida Legislature.

A similar publication was prepared for the 1971 and 1972 Sessions of the Legislature. The three issues of the pamphlet have been well received.

5. **1972 Legislative Accomplishments**—During the 1972 Legislative Session, there were 233 legislative proposals that required the action of the State Legislative Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

- Passage of legislation to assist in the development of hospital and medical society review by providing protection to the physicians who serve on these committees;
- Reform of Florida's abortion law;

—Defeat of legislation which would provide mandatory insurance coverage for chiropractic services;

—**Health Maintenance Organizations**—The general objective of the committee in the area of Health Maintenance Organizations (HMO) was to make sure that any legislation enacted would not interfere with the private practice of medicine and contained reasonable quality controls to insure delivery of quality medical care through any HMO that might be established. The legislation which passed (SB 498) was in keeping with this overall objective and conformed to FMA policy on HMO's as established by the Board of Governors.

In the initial stages of the development of this legislation, efforts were made to require that contracts which an HMO has with private physicians must be approved by the State of Florida and that the individual physician's office records (both fiscal and medical) would be open to inspection by the state. As a result of intensive effort by the FMA staff and key contact physicians, these proposals were defeated.

6. **Major Legislative Objectives for 1973 Session**—The major legislative objectives for the 1973 session of the Florida Legislature as established by the FMA House of Delegates and the FMA Board of Governors were:

- Equitable funding for Florida's Title XIX (Medicaid) program;
- Passage of legislation to protect the records of hospital and medical society review committees from discovery;
- Opposition to legislation which would require all insurance companies to cover chiropractic services in all policies written in the State of Florida;
- Passage of legislation to establish a statewide emergency medical services system;
- Passage of legislation which would require comprehensive health education programs in all public schools of this state;
- Opposition to the repeal of the anti-substitution law for prescriptions;
- Creation of legislative study in the area of professional liability insurance problems.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA Legislative program made during the 1973 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

**Committee on Government Programs**—Perhaps the most outstanding accomplishment of the Committee on Government Programs in the past year has been to establish firmly a working liaison with the secretary of the Florida Department of Health and Rehabilitative Services. As a result of the committee efforts a formal conference was established to explore means for better liaison between the medical and dental professions in the State of Florida and to solicit ideas as to how the problems currently being faced by the professions in the state might be solved. A second conference has been rescheduled for the month of September, during which time it is anticipated that several specific problems currently being experienced by the professions in dealing with the State of Florida will be explored in detail.

Secretary Emmett Roberts, of the Department of Health and Rehabilitative Services, and key members of his staff met with the committee chairman and members of the committee on numerous occasions during the past year. As a direct result of these conferences, major changes have been proposed in the Medicaid program to the 1973 Legislature. Progress has also been made in the areas of drug abuse, improvement of medical services to the institutional population of Florida, and improvements to the mental health commitment law (Baker Act). The committee anticipates maintaining active liaison with the Department during the coming year.



## **Supplemental Report Committee on State Legislation**

The Reference Committee reviewed each item contained in the report and was informed that the Governor's Supplemental Budget Request included a substantial increase in the funding of the Florida Medicaid Program. The Committee pointed out that the funding is still below that required to provide for usual, customary, and reasonable fees. The Chairman of the Committee on State Legislation indicated to the Reference Committee that this was the goal of his Committee and that they are working toward it in accordance with the policy previously established by this House, and also that the Discovery Bill, which protects the records of hospitals and medical society review committees, has been enacted by both houses and is now on the Governor's desk.

The Reference Committee commended the Committee on State Legislation and especially its Chairman, Sanford A. Mullen, M.D., the members of the Woman's Auxiliary who have worked so effectively in our legislative efforts, and Mr. Donald S. Fraser Jr., the Director of our office in Tallahassee. They also commended especially the many members of our Association who have cooperated so well in our implementation of legislative programs.

Upon recommendation of Reference Committee No. IV, the Supplemental Report of the Committee on State Legislation was filed.

### **Council on Specialty Medicine Recommendation 1 (School of Optometry)**

The Reference Committee pointed out that the inclusion of the phrase "by every means" in the "RESOLVED" of Recommendation 1 of the Council on Specialty Medicine might create difficulty in the establishment of legislative priorities for 1974 and recommended that these words be deleted.

The amendment was adopted, and Recommendation 1 was adopted as amended.

(See Report of Council on Specialty Medicine, page 36)

### **Council on Medical Services Recommendation 5 (Physical Examinations—Indigent Children)**

The Reference Committee recommended an amendment to Recommendation 5 of the Council on Medical Services, deleting the word "high", as this might interfere with the establishment of

priorities for the 1974 Legislative program. The amendment was adopted.

Recommendation 5 of the Council on Medical Services was adopted as amended.

(See Report of Council on Medical Services, page 44.)

### **Council on Medical Services Recommendation 13 (Prenatal Testing for Gonococcus)**

The Reference Committee recommended that Recommendation 13 of the Council on Medical Services be adopted. It was adopted.

(See Report of the Council on Medical Services, page 44).

### **Council on Medical Services Recommendation 14 (Statewide Medical Examiners System)**

The Reference Committee noted that adequate funding for the Florida Statewide Medical Examiners System may not be provided in the current legislative session but was impressed with the need for adequate funding. The Committee feels that serious consideration should be given to this recommendation in the development of legislative priorities for 1974.

The Reference Committee recommended that Recommendation 14 of the Council on Medical Services be referred to the Board of Governors for action by the Committee on State Legislation in the development of legislative priorities for 1974.

The recommendation of the Reference Committee was adopted, and Recommendation 14 was referred to the Board of Governors.

(See Council on Medical Services Report, page 44.)

### **Council on Medical Services Recommendation 15**

The Reference Committee recommended adoption of Recommendation 15 of the Council on Medical Services.

It was adopted.

(See Council on Medical Services Report, page 44.)

## **Board of Governors Report**

### **Board Action No. 17 Recommendation No. 8 Comprehensive Health Planning**

The Reference Committee recommended adoption of Recommendation No. 8 of the Board of



Governors Report.

It was adopted.

(See Board of Governors Report, page 52.)

### **Board Action No. 19 Legislation**

The Reference Committee recommended that Board Action No. 19 be adopted, with the exception of the second paragraph [which is discussed later in the report, and which was not adopted (see page 53)].

It was adopted as amended.

(See Board of Governors Report, page 53.)

### **Resolution 73-9 Anti-Substitution Laws Duval County Medical Society**

The Reference Committee recommended amendment of the resolution by deleting the word "actively" in the second "RESOLVED".

Resolution 73-9 was adopted as amended.

### **Resolution 73-9 Anti-Substitution Laws**

RESOLVED, That the Florida Medical Association reaffirm its current position of deploring substitution by pharmacist of medications unless approved by the prescribing physician, and further be it

RESOLVED, That the Florida Medical Association oppose any and all attempts to repeal or amend the anti-substitution laws of Florida which would give the pharmacist permission to substitute medications prescribed by the physician without the physician's permission.

### **Resolution 73-13 State Allocations for Control of Drug Abuse Everett Shocket, M.D., Delegate**

The Reference Committee recommended that the resolution be referred to the Board of Governors for consideration with other legislative items in formulating the legislative priorities from Florida Medical Association for 1974.

The recommendation to refer Resolution 73-13 to the Board of Governors was adopted.

### **Resolution 73-13 State Allocations for Control of Drug Abuse [NOT ADOPTED—REFERRED TO BOARD OF GOVERNORS]**

Whereas, The drug abuse epidemic is of concern to all Floridians, and is primarily of concern to the physicians of Florida, and

Whereas, The Federal Government contributed to the State of Florida \$6,595,112 in 1972 and the local communities of Florida contributed, in toto \$2,393,396, the State of Florida in 1972 contributed only \$495,240, therefore be it

RESOLVED, The Florida Medical Association urge the Florida Legislature to allocate adequate state funds at a dollar level consonant with the state's need in controlling this disease and consonant with the interest already evidenced by the Florida Legislature when it established hallmark guidelines for licensing of drug rehabilitation centers.

### **Resolution 73-14 Governing Bodies of Non-Profit Hospitals Everett Shocket, M.D., Delegate**

The Reference Committee was concerned about the involvement of the Florida Legislature in determining terms of trustees of non-profit organizations and therefore felt that this resolution would or could result in sweeping changes in non-profit organizations which may be very undesirable.

The Reference Committee recommended that Resolution 73-14 not be adopted.

Resolution 73-14 was not adopted.

### **Resolution 73-17 Chiropractic Alachua County Medical Society**

The Reference Committee recommended that the words "continued and" be deleted from this resolution, and that it be adopted as amended.

Resolution 73-17 was adopted as amended.

### **Resolution 73-17 Chiropractic**

RESOLVED, That the Florida Medical Association is opposed to the future licensure of practitioners of chiropractic within the State of Florida and will seek and support reasonable legislation to prohibit altogether the practice of chiropractic within the State of Florida.

### **Resolution 73-24 Comprehensive Alcoholism Prevention, Control, and Treatment Act Volusia County Medical Society, Inc.**

The Reference Committee heard testimony which indicated that the Comprehensive Alcoholism Prevention, Control and Treatment Act, Public Law 71-132 (the Myers Act) is now under serious discussion by the Florida Legislature. Funding for this Act appears to be inadequate and the administrative complexities of the Act are much greater than anticipated. For these reasons the Reference Committee was advised that the Florida Legislature may well defer implementation of the Act for at least one year so that it can be studied and possibly revised. Resolution 73-24 is consonant with this concern of the Legislature.

The Reference Committee recommended adoption of this resolution.

Resolution 73-24 was adopted.

## **Resolution 73-24**

### **Comprehensive Alcoholism Prevention, Control, and Treatment Act**

RESOLVED, That the Florida Medical Association respectfully requests the 1973 Florida State Legislature to re-examine and reconsider this act with the purpose of either amending it, with full funding for its implementation; or repealing it.

## **Resolution 73-26**

### **Proposed Mandatory Sickle Cell Screening Duval County Medical Society**

The first "Resolved" of Resolution 73-26 was referred to Reference Committee IV and the Reference Committee recommended that this first "Resolved" be adopted.

It was adopted.

(See Report of Reference Committee I, page 38.)

### **Council on Medical Services, Recommendation 11 Board of Governors Report: Board Action No. 19**

#### **Resolution 73-3—Child Health Services**

##### **Nassau County Medical Society**

#### **Resolution 73-20—Bureau of Crippled Children**

##### **Sarasota County Medical Society**

The Reference Committee indicated that these recommendations and resolutions were considered together because they dealt with the same subject. Testimony during the Committee meeting indicated the need for a clear statement involving the issues contained in these recommendations and resolutions so the Reference Committee solicited advice from several of the witnesses who appeared before the Committee and they provided great help to the Committee in the development of a statement on the issues involved.

The Reference Committee recommended adoption of a substitute resolution for Resolution 73-3 and Resolution 73-20, to be called Substitute Resolution 73-3, to accomplish the objectives of both resolutions as well as that of Council on Medical Services Recommendation 11 and Board of Governors Action No. 19, paragraph 2.

Substitute Resolution 73-3 was adopted.

## **Substitute Resolution 73-3**

### **Child Health Services**

RESOLVED, That the following statement be adopted relative to the State of Florida and its involvement in Health Services for Children:

The Florida Medical Association believes strongly that the children of Florida should receive the best

possible health services. Any involvement of the State in child health services must be accomplished through the structure of state government. The established structural levels in state government are: Governor, Departments, Divisions, Bureaus, Sections. There are now two agencies of state government which have the major responsibility for child health services:

1. Bureau of Crippled Children in the Division of Vocational Rehabilitation (in the Department of Health and Rehabilitative Services).

2. Child Health Section in the Division of Health (in the Department of Health and Rehabilitative Services).

The Florida Medical Association supports the plan to raise the Bureau of Crippled Children to Division level in the Department of Health and Rehabilitative Services and the Child Health Section to Bureau level in the Division of Health. These two agencies have separate functions and no efforts are being proposed to change their areas of responsibility. The Florida Medical Association believes that the establishment of a Division of Crippled Children in the Department of Health and Rehabilitative Services and a Bureau of Child Health in the Division of Health will be a major step toward achievement of the goal for the children of Florida to receive the best possible health services. These organizational changes provide a logical beginning for the establishment of a separate Department of Health in accordance with existing Florida Medical Association policies.

### **Council on Medical Services Recommendation 11**

The Reference Committee recommended that Recommendation 11 of the Council on Medical Services not be adopted.

Recommendation 11 was not adopted.

(See report of the Council on Medical Services, page 44.)

### **Board of Governors Action No. 19 (Second Paragraph)**

The Reference Committee recommended that the Board of Governors Action No. 19, second paragraph not be adopted.

It was not adopted.

(See Board of Governors Report, page 53.)

Dr. Coleman: "Your Chairman wishes to thank the members of this committee, Doctors John A. Rush, Henry L. Harrell, Charles A. Monnin, and Curtis W. Cannon, the members who came to speak before the committee and our secretary, Mary Ann Brown, without whose efforts, cooperation and assistance this report would not have been possible."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. IV as a whole."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. IV."



# Report of Reference Committee No. V

## Medical Economics

The Speaker assumed the Chair and called for the report of Reference Committee No. V, Medical Economics.

Dr. Miles J. Bielek, Chairman, came forward to present the report of Reference Committee No. V, Medical Economics.

### Council on Medical Economics

The Reference Committee recommended that the following lines be deleted from the Report of the Council on Medical Economics, "Vocational Rehabilitation currently pays a usual and customary fee for services they purchase with a ceiling set by a conversion factor with the 1971 Relative Value Studies Manual, although these ceiling values are below average fee levels found by the committee in 1971," and the following recommendation be substituted: "We recommend that Vocational Rehabilitation payments for services be made at the current UCR level."

The amendment was adopted.

Upon recommendation of the Reference Committee, the report of the Council on Medical Economics was adopted as amended.

### Council on Medical Economics

VERNON B. ASTLER, M.D., *Chairman*

The Council met twice during the year, August 30, 1972, and March 18, 1973. Most of the committees of the Council have been very active during the past year.

The following is a summary of the activities and recommendations of the committees under the Council on Medical Economics:

**Committee on Advisory to Blue Shield and Fiscal Intermediaries**—The committee met four times during the year beginning with a breakfast meeting at the Florida Medical Association Annual Meeting on May 5, 1972, followed by meetings on August 27, 1972, in Tampa, December 2, 1972, in Jacksonville and March 4, 1973, in West Palm Beach.

The committee functioned very well during the year with the addition of Mr. Mike O'Farrell of Blue Shield as staff representative to the committee. Mr. O'Farrell has coordinated the functions of the committee with the new FMA staff representative, Mr. John B. Richardson with no difficulty and this arrangement is working very well.

The Chairman and FMA Staff to the committee, accompanied by various members of the committee, attended all Blue Shield Board of Directors meetings. The committee also mailed out four newsnotes to the physicians in Florida, and had three articles published in the *Journal of the Florida Medical Association*.

The committee attempted to publish a summary of its activities and actions in the *Journal of the Florida Medical Association*; but because of the time lag necessary for items to be published in the Journal, the com-



Miles J. Bielek, M.D., Ft. Lauderdale (standing) was Chairman of Reference Committee V. His Committee included (left to right): John N. Carlson, M.D., Sarasota; Hoke H. Shirley Jr., M.D., Naples; and William W. O'Connell, St. Augustine. Mrs. Linda Cearnal served as secretary to the Committee.



mittee plans to return to a newsletter to keep Florida physicians informed of its activities and actions.

The committee was instrumental in Blue Shield changing the wording on its master medical and federal supplemental explanations sent out with payments. These explanations no longer make references to "usual and customary," but simply states "exceeds limit of liability of contract" whenever a physician's fee is not allowed in full. The committee also suggested a compromise to the Social Security Administration on the issue of "more than allowable charge" on the Explanation of Medicare Benefits. The wording "this payment does not necessarily cover the physician's entire fee" now appears in the remarks section of the EOMB, supplementing the phrase "more than allowable charge" on unassigned claims. The Social Security Administration would not substitute the latter phrase, but agreed to add it to the EOMB. Also, all Blue Shield Remittance Advices for Indemnity Contracts now state "the benefits provided by this contract do not necessarily cover the physician's entire fee."

The committee made various suggestions to the Florida Medical Association and Blue Shield on how to improve the review system involving the Blue Shield Claims Committee and the Florida Medical Association Health Insurance Committee.

At the recommendation of the committee, Blue Shield is now in the process of reviewing and revising some of its form letters used for Medicare B and Blue Shield's private business. The committee is to review these changes with Blue Shield staff.

The committee suggested that Blue Shield Complementary Coverage "Medicare Supplement" expand its coverage to supplement the Medicare payment over to the Blue Shield usual, customary and reasonable 90th percentile, rather than the Medicare "reasonable" determination. Blue Shield has initiated a marketing survey to determine if there is a market for this suggested change.

At the suggestion of the committee, Blue Shield is now preparing a manual on how to file claims for all Blue Shield programs.

**Committee on Health Insurance**—The committee met three times during the year, July 15, 1972, February 3, 1973, and March 17, 1973.

There has been much controversy surrounding the activities of this committee during the last year. On January 13, 1973, the Board of Governors approved a set of formal operating procedures for the committee. With the approval of the operating procedures, the committee is beginning to function in an efficient and effective manner.

The fact that there are varying fees for the same procedures in different geographic regions in the state led the committee to request direction from the Board of Governors as to what should constitute a "charge area" in determining useful and customary fees. The Executive Committee directed that the Association utilize the three fee districts currently being used by Blue Shield of Florida for Medicare as Florida Medical Association areas in determining usual and customary or prevailing fees.

One seemingly prevalent problem that the committee sees more and more of is the case where a physician has not sufficiently documented in his operative notes the procedure performed during the surgery. Several cases reviewed by the committee would have been paid in full by the insurance company, had the doctor documented his operative notes sufficiently.

During the past year, the committee has received 69 requests for claims from insurance companies, which have been forwarded to the respective county medical societies. Nineteen of these were appealed to the State Committee, 15 of which have been reviewed, and at the present time four are in abeyance, which will be reviewed at the next meeting.

Insofar as recommendations for the coming year are concerned, the committee feels very strongly that the House of Delegates should consider the functions of this committee, and strongly support the operation of this committee. The committee considers this quite important

in view of some strong objections that have been voiced concerning the actions of the committee.

**Committee on Hospitals and Extended Care Facilities**—The committee held one telephone meeting during the year on March 16, 1973. The Chairman attended several seminars presented by the American Medical Association on Hospitals and Extended Care Facilities, most recently a seminar on "The Role of the Medical Director in the Long-Term Care Facility" on March 2 and 3, 1973.

During the coming year, the committee plans to review and revise the Model Medical Staff By-Laws utilizing the manual published by the *Joint Commission on Accreditation of Hospitals* entitled, "Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations."

**Committee on Computerization in Medicine**—The committee held an informal meeting on May 3, 1972.

The aspect of Emergency Medical Communications was removed from the committee and transferred to the purview of the Council on Medical Service, specifically, the Committee on Emergency Medical Service. John C. Turner, M.D., was relieved as Chairman of this committee to allow him to channel his efforts toward Emergency Medical Communications as Vice Chairman of the Committee on Emergency Medical Service. Richard D. Hoover, M.D., was appointed as the new Chairman of the committee.

**Committee on Peer Medical Utilization Review**—The committee met nine times this past year for 1,635 physician man-hours and have reviewed 210 cases. The largest segment of these reviews have been concerned with hospital practices. Approximately sixty-five percent have resulted in recommendations of "No Problem." Many of the cases have been heard via the appeal process more than once. The committee considers its function as twofold. One—to provide a fair and equitable hearing for each physician involved, and two—to provide a forum which might serve as an educational experience for all.

At the request of the Board of Governors, the committee became involved in the review of Mount Sinai's hospital-based physicians. This review resulted in the Committee's largest single review consisting of the review of 2,100 patient charts. Eighty-three physicians were required including the committee. These physicians expended 832 physician man-hours. The recommendations were turned over to the carrier and at this date the results are not known. The committee in its review of Mount Sinai's hospital-based physicians had presented to it a new and rather unique problem necessitating new tools. The Utilization Department, Part B, provided these tools and it is believed that this method which was used for this review will become the guide for Florida peer review in the future.

The committee developed as a guideline a set of standard operating procedures for PMUR. These were approved by the Board and have been the operational guide for the committee. These were also distributed to each county medical society with the request that they be used as guides at the local level.

With the passage of PSRO (PL 92-603) we are entering a new era. Approval has at last been granted by the Board of Governors and the Blue Shield Board for Medicare to request prior to peer review copies of a physician's records for that area which appears to deviate from the norm. This program has now been initiated and the requests have been made. From the returns at this time, the peer review load is being reduced approximately 50%. The medical consultants at Medicare are able to justify from the records received the deviation from norm. However, if these arrangements are unsatisfactory to the physician (review of records prior to peer review), he has the right to refuse to provide these records and to a full peer review process.

The committee wishes to commend each and every county medical society committee who has been faced with the responsibility of peer review. We know that it has not been pleasant for either the reviewing physician or the physician being reviewed.

Each member of this committee is to be commended for their dedication and devotion to a most unpleasant task. Each of them have served the committee and the Association to their fullest and deserve far more than a simple thank you for a job well done.

**Committee on Relative Value Studies**—The 1971 Relative Values Studies Manual was completed and printed in early 1972. This involved exhaustive surveys and post survey meetings, consultations with other committees and study over 2½ years before the Manual was published. All code numbers and nomenclature in the Manual were taken from Current Procedural Terminology, Second and Third Editions, published by the AMA.

Reception of the Manual has been quite good. Several questions and complaints relating to pediatric procedures, ophthalmology, neurosurgery and total obstetrical care have either been settled by the committee or are being currently studied. Two meetings have been held by the committee during the year, and only minor changes have been made in the Manual to date.

National Blue Shield and HEW-Medicare have been extremely slow to accept CPT as a standard nation-wide terminology and this has retarded use of the 1971 RVS Manual. While Florida Blue Shield does encourage use of the Manual in filing claims, use of the Manual is not obligatory, and the new Manual and CPT are still in an investigative period in Florida Blue Shield, it is understood. However, there is a gradual trend toward adoption of CPT as a standard terminology and coding nationwide, and it is anticipated that the 1971 Manual and its successors will have much wider use once the shift to CPT terminology is finally accomplished.

It is significant that the Florida Vocational Rehabilitation Service has adopted the 1971 Relative Values Manual with conversion factors and with some change in the code numbers to accommodate their computer service. It is understood that the Manual has worked well for Vocational Rehabilitation Service. All of the State of Florida agencies purchasing medical care from private physicians are studying adoption of a uniform method and scale of paying fees. Vocational Rehabilitation Service use of the new RVS Manual will quite possibly be the prototype for this arrangement.

## RECOMMENDATION

We recommend that Vocational Rehabilitation payments for services be made at the current UCR level.

One further meeting of the Relative Values Studies Committee is planned at the time of the FMA Annual Meeting to evaluate results of a resurvey of certain obstetrical procedures, particularly total obstetrical care and possible Manual changes depending on the data submitted. Dr. William Howard, Ph.D. of Gainesville, continues as a part time consultant to the committee and has conducted and evaluated the survey material on earlier surveys conducted during 1972-1973.

## Report of Board of Governors

### Recommendation No. 4 Resolution 72-11 Medicare Terminology—More Than Allowable Charge

The Reference Committee recommended that Recommendation No. 4 concerning Resolution 72-11, be adopted as printed in the handbook,

taking into consideration that the phrase "more than allowable charge" on unassigned claims has been supplemented with the wording "this payment does not necessarily cover the physician's entire fee" as now appears in the remarks section of Explanation of Medicare Benefits.

It was adopted.

(See Report of Board of Governors, page 50.)

### Board of Action No. 1 Peer Medical Utilization Review

Upon recommendation of the Reference Committee, Board Action No. 1 was adopted.

(See Report of Board of Governors, page 50.)

### Board Action No. 2 Ad Hoc Committee on Workmen's Compensation

The Reference Committee recommended that Board Action No. 2 be adopted as printed.

It was adopted.

(See Report of Board of Governors, page 51.)

### Board Action No. 3 Resolution No. 72-32 Medicare—Explanation of Medical Benefits

The Reference Committee recommended that Board Action No. 3 be adopted as printed.

A motion was made from the floor to table the action.

The motion to table was defeated after a vote of the House.

There was discussion.

Board Action No. 3 was adopted.

(See Report of Board of Governors, page 51.)

### Board Action No. 15 Resolution No. 71-24 Medicare Program Benefits

Upon recommendation of the Reference Committee, Board Action 15 was adopted as printed.

(See Report of Board of Governors, page 51.)

### Board Action No. 21 New Professional Liability Insurance Program

Upon recommendation of the Reference Committee, Board Action No. 21 was adopted as printed.

(See Report of Board of Governors, page 53.)



**Board Action No. 22  
FLAMEDCO, Inc.**

Upon recommendation of the Reference Committee, Board Action No. 22 was adopted as printed.

(See Report of Board of Governors, page 53.)

**Board Action No. 25  
Insurance Review Procedures**

Upon recommendation of the Reference Committee, Board Action No. 25 was adopted as printed.

(See Report of Board of Governors, page 53.)

**Board Action No. 26  
PMUR Operating Procedures**

Upon recommendation of the Reference Committee, Board Action No. 26 was adopted as printed.

(See Report of Board of Governors, page 53.)

**Board Action No. 30  
PSRO (Professional Standards  
Review Organization)**

The Reference Committee made the recommendation that Board Action 30 be amended by inserting the word "reluctantly" following the word "Governors" in the first sentence and that it be adopted as amended.

A substitute motion was made and seconded from the floor which recommended delaying moderately the establishing of a Florida PSRO Corporation, signing no contract with H.E.W., until such time as more complete information pertinent to PSRO may be presented to the Board of Governors.

There was discussion.

The substitute motion was defeated.

The Reference Committee's amendment was adopted and Board Action No. 30 was adopted as amended.

(See Report of the Board of Governors, page 53.)

**Board Action No. 34  
Recommendation No. 12  
Blue Shield**

Upon recommendation of the Reference Committee, Board Action No. 34, Recommendation No. 12, was adopted as printed.

(See Report of the Board of Governors, page 54.)

**Board Action No. 35  
Recommendation No. 13  
Medicare Contract**

The Reference Committee recommended that Board Action No. 35, Recommendation No. 13 be adopted as printed.

A motion was made and seconded from the floor to amend the recommendation by adding, "Be it further recommended that the Board review programs in other states and those provided by other companies to determine which might better serve the needs of our patients and the best interest of the physicians of Florida."

There was discussion.

The motion to amend was defeated.

Board Action No. 35, Recommendation No. 13, was adopted as printed.

(See Report of the Board of Governors, page 55.)

**Board Action No. 36  
Recommendation No. 14  
Dual Fee Schedule**

Upon recommendation of the Reference Committee, Board Action No. 36, Recommendation No. 14 was adopted as printed.

(See Report of the Board of Governors, page 55.)

**Supplemental Report—Board of Governors  
FMIT Program  
Recommendations No. 16 and No. 17**

The Reference Committee, after much deliberation, recognized the fact that the FMIT Program, for what it covers, is worth the high cost; but a more reasonable program should be developed by FMIT, and the Committee called this to the attention of FMIT, delegates and members.

The Reference Committee recommended that FMIT Program, Recommendations No. 16 and 17 be adopted.

They were adopted.

(See Supplemental Report of the Board of Governors, page 56.)

**PMUR Program—Mount Sinai Hospital**

Upon recommendation of the Reference Committee, this action was adopted.

(See Supplemental Report of the Board of Governors, page 56.)



**Blue Shield—UCR Program  
Recommendation No. 18**

**Resolution No. 73-21**

**Usual, Customary and Reasonable Health  
Insurance Plans  
Brevard County Medical Society**

The Reference Committee noted that Blue Shield, UCR Program, Recommendation No. 18 and Resolution No. 73-21—Usual, Customary and Reasonable Health Insurance Plans, are related but diametrically opposed and should be considered at the same time, but voted on separately.

**Blue Shield—UCR Program  
Recommendation No. 18**

The Reference Committee recommended that the following sentence be added at the end of the first paragraph of the recommendation: "In UCR determinations, no percentile less than the 90th shall be used."

The Reference Committee also recommended that Blue Shield be requested to send a form to each participating physician for his approval of UCR contracts. This form should be returned signed, approved or not approved.

Recommendation No. 18 was adopted as amended.

(See Supplemental Report of the Board of Governors, page 56.)

**Resolution No. 73-21**

**Usual, Customary and Reasonable Health  
Insurance Plans**

The Reference Committee recommended that the resolution not be adopted.

Resolution No. 73-21 was not adopted.

**Ad Hoc Committee on Workmen's Compensation**

Upon recommendation of the Reference Committee, the Report of the Ad Hoc Committee on Workmen's Compensation was adopted with commendation to the Committee.

**Ad Hoc Committee on  
Workmen's Compensation**

JOSEPH G. MATTHEWS, M.D., *Chairman*

On July 20, 1972, the most recent adjustments in the Medical-Surgical Fee Schedule went into effect. These changes are:

Follow-up Hospital Visit—\$8.00  
Conversion factor for Surgery, Medicine and Anesthesiology—\$6.50  
Anesthesia time units—ten minutes.  
Conversion factor for Radiology and Pathology—\$6.00  
Physical therapy treatments by the doctor or his aide

1 Modality —\$ 8.00

2 or more modalities—\$10.00

Physical therapy by registered physical therapists will be—Usual and Customary—whether in a private doctor's office or in a physical therapist's office.

Since that date there have been no further hearings called regarding fees for this year, and the ad hoc committee has received practically no correspondence from doctors complaining of the present existing fee schedule.

A member of the ad hoc committee is scheduled to attend the March hearing on problems of workmen's compensation, and will discuss the FMA's concern about the requirement that medical reports be supplied patients or their attorneys free of charge. There will be an effort made to change the wording in this section.

It is felt that sometime in the future the practicing doctors of Florida should be polled again to determine whether the allowable fees for treating workmen's compensation cases are still at the level which prevailed around the state for treating other types of patients with similar injuries. It is hoped that enough doctors in Florida will be using the 1971 Relative Value Studies, that we can insist this document be the basis of future workmen's compensation fee schedules.

It is now obvious that all future fee adjustments must be stimulated by organized medicine's efforts and that we must continue to do our own investigations regarding the fairness or unfairness of current fee schedules.

**Resolution No. 73-1**

**Mandatory Certificate of Need and Health  
Planning Councils  
Palm Beach County Medical Society**

The Reference Committee recommended that Resolution No. 73-1 be adopted.

A motion was made and seconded to amend the resolution by deleting the words "and personnel" and adding "non-tax supported" before the words "health facilities."

There was discussion.

The motion to amend was defeated.

Resolution No. 73-1 was adopted.

**Resolution 73-1**

**Mandatory Certificate of Need and Health  
Planning Councils**

RESOLVED, That the Florida Medical Association go on record as being opposed to the Mandatory Certificate of Need for health facilities and personnel, and furthermore, be it

RESOLVED, That a copy of this Resolution be forwarded to the American Medical Association for its consideration.

**Resolution 73-2**  
**Professional Fees in Teaching Hospitals**  
**Duval County Medical Society**

The Reference Committee considered Resolution No. 73-2 and recommended that it be referred to the Board of Governors.

There was discussion.

Resolution No. 73-2 was referred to the Board of Governors.

**Resolution 73-2**

**Professional Fees in Teaching Hospitals**  
[NOT ADOPTED—REFERRED TO BOARD OF  
GOVERNORS]

Whereas, The teaching program of University Hospitals are jeopardized by certain proposed administrative rulings of the Department of Health, Education and Welfare which affect Medicare and Medicaid programs by limiting professional fee payments to 20% of usual and customary fee as a supervisory fee for the physician attending at surgery and directing patient care following surgery

Whereas, Teaching programs across this country are underfunded and such a practice would further limit department budgets, and

Whereas, Faculty physicians are customarily limited to a maximum remuneration drawn from a teaching fund, and

Whereas, The teaching fund customarily receives all professional fees and any excess professional fee goes to support the department teaching services therefore, be it

RESOLVED, That the Florida Medical Association vigorously protest any new limitation of fees paid for patient care, on teaching services given to the physician participating in this care, and a copy of this resolution be sent to the American Medical Association for its approval.

**Resolution 73-7**  
**Blue Shield**  
**Duval County Medical Society**

Upon recommendation of the Reference Committee, Resolution 73-7 was adopted.

**Resolution 73-7**

**Blue Shield**

RESOLVED, That the House of Delegates of the Florida Medical Association express its appreciation to the laymen and physicians who have served their fellow citizens by serving on the Blue Shield committees and Board of Directors, and be it further

RESOLVED, That this House of Delegates, as in years past, reaffirms its confidence in the Board of Directors and employees of Blue Shield and urges them to continue to carefully guard the interest of the physicians of Florida, as well as those of its subscribers.

**Resolution 73-8**  
**Blue Shield**  
**Duval County Medical Society**

The Reference Committee recommended that Resolution No. 73-8 be amended by deleting



The Newly elected Board of Governors get together to begin FMA's 1973-74 business year. Front row: Fredrick C. Andrews, M.D., Mt. Dora, Vice President; Franklin J. Evans, M.D., Coral Gables, Speaker of the House; William J. Dean, M.D., St. Petersburg, Immediate Past President; Joseph C. Von Thron, M.D., Cocoa Beach, President; Thad Moseley, M.D., Jacksonville, President-Elect; James W. Walker, M.D., Jacksonville, Secretary-Treasurer; Floyd K. Hurt, M.D., Jacksonville, Past President. Second row: W. Harold Parham, Jacksonville, Executive Vice President; Vernon B. Astler, M.D., Boynton Beach, Florida State Board of Medical Examiners; Jack A. MacCris, M.D., St. Petersburg, Medical District "B"; Thomas B. Thames, M.D., Orlando, Medical District "C"; Richard C. Dever, M.D., Miami, Medical District "D"; Robert E. Zellner, M.D., Orlando, Blue Shield of Florida; Eugene G. Peek Jr., M.D., Ocala, Department of Health and Rehabilitative Services; William M. C. Wilhoit, M.D., Pensacola, Medical District "A"; Burns A. Dobbins Jr., M.D., Ft. Lauderdale, AMA Delegate and Jack T. Bechtel, M.D., Indiatlantic, At Large.



"25%" and substituting "35%" in the first "RESOLVED," and that the word "and" be deleted and substituted with the word "or" after the phrase "to the patient," and correct the word "required" in the second "RESOLVED" to read "requested."

A substitute resolution was presented from the floor to take the place of Resolution 73-8.

An amendment to the substitute resolution was made and seconded from the floor to include the second "RESOLVED" of the original resolution in the substitute resolution.

There was discussion.

The amendment was defeated.

The substitute motion was adopted.

## **Substitute Resolution 73-8**

### **Blue Shield**

RESOLVED, That Blue Shield be asked to make a study of those claims in which the benefits paid are reduced by 35% or more, and be it further

RESOLVED, That a report of this study be presented to the Board of Governors at its January, 1974, meeting.

### **Resolution 73-11**

#### **Other State Blue Shield Plans Dade County Medical Association**

The Reference Committee recommended the adoption of a substitute resolution for Resolution No. 73-11.

The substitute resolution was adopted.

## **Substitute Resolution 73-11**

### **Other State Blue Shield Plans**

RESOLVED, That the Florida Medical Association contact the state medical associations of New York, New Jersey and Pennsylvania and point out the problem of collecting for care of tourists from those states that have Blue Shield coverage in their home states, and that this also be referred to the Blue Shield Board for similar action with the Blue Shield Boards in the states mentioned.

### **Resolution 73-12**

#### **In-Hospital Test Charges Everett Shocket, M.D., Delegate**

The Reference Committee recommended that the resolution be amended to read, "RESOLVED, That the Florida Medical Association urge county medical societies to request that each hospital staff be provided by their hospital administration,

with a current list of charges, to be placed at multiple, accessible locations."

A motion was made from the floor to amend the recommendation by adding the words, "for all services" after "list of charges." The motion carried.

The Reference Committee recommendation was adopted as amended, and Resolution 73-12 was adopted as amended.

## **Resolution 73-12**

### **In-Hospital Test Charges**

RESOLVED, That the Florida Medical Association urge county medical societies to request that each hospital staff be provided by their hospital administration, with a current list of charges for all services, to be placed at multiple, accessible locations.

### **Resolution 73-18**

#### **Blue Shield—Master Medical Coverage Duval County Medical Society**

The Reference Committee recommended that Resolution No. 73-18 be referred to the Board of Governors to facilitate the development of a form to eliminate the multiple forms referred to in the resolution.

Resolution No. 73-18 was referred to the Board of Governors.

## **Resolution 73-18**

### **Blue Shield—Master Medical Coverage**

[NOT ADOPTED—REFERRED TO BOARD OF GOVERNORS]

Whereas, It is desirable to improve the image of Blue Shield, and

Whereas, Confusion is engendered by multiple forms being required, in filing for benefits that subscribers are entitled to, and

Whereas, People are entitled to receive all the benefits they have paid for, and

Whereas, Florida Medical Association Resolution 72-17 clearly stated that "... all new contracts provide the usual, customary and reasonable coverage or coverage that will provide at least 60 per cent of usual, customary and reasonable fees." and,

Whereas, In order for the contracts sold by Blue Shield to meet the criterion of Resolution 72-17, for example to employees of the State of Florida, they must have the benefits of their Master Medical coverage paid, and

Whereas, In fact, the Master Medical is not paid without the filing of additional forms and since many persons covered do not realize this is necessary in order to receive benefits to which they are entitled, be it

RESOLVED, That it be recommended to the Board of Directors of Blue Shield of Florida that Blue Shield basic benefits coverage and Master Medical coverage be paid directly to the physician or to the subscriber, as indicated on doctors service report, without the necessity for multiple forms or multiple assignments in all instances where Master Medical or extended benefits are entitled to be paid.



**Resolution 73-22**  
**Relative Values of Surgical Procedures**  
**William H. Meyer, Jr.**  
**Member, Council on Specialty Medicine**  
**(Representative of Florida Association**  
**of General Surgeons)**

The Reference Committee recommended that Resolution No. 73-22 be adopted as printed in the handbook.

There was discussion.

A substitute resolution was presented from the floor to replace Resolution 73-22.

The substitute resolution was adopted.

**Substitute Resolution 73-22**

**Relative Values of Surgical Procedures**

RESOLVED, That Florida Medical Association continue an on-going study for revisions that may be necessary in the Relative Value Studies in all areas, and be it further

RESOLVED, That a vote of commendation be given for the efforts of those who worked to give us our present Relative Values Studies.

**Resolution 73-25**  
**Free-Standing Surgical Clinics**  
**St. Johns County Medical Society, Inc.**

The Reference Committee recommended that the Resolution be amended by changing the subject to "Free-Standing Surgical Centers"; delete the words "the insistence upon" and "Blue Shield" in the first sentence of the "RESOLVED"; and delete the words "to patients" in the first sentence, and that the resolution be adopted as amended.

The amendments were adopted, and Resolution 73-25 was adopted as amended.

**Resolution 73-25**

**Free-Standing Surgical Centers**

RESOLVED, That the Florida Medical Association endorse and actively pursue payment by Blue Cross and commercial insurance carriers for services rendered in such facilities provided:

- a. The facility's accounts receivable are always separate and independent of the professional component of the patient's fee, and
- b. Adequate clinical and administrative records are kept of each patient so that valid audits can be made, and



Dr. W. J. Lewis, Chairman of the AMPAC Board of Directors poses with Dr. Von Thron and the top achievement award won by Florida.

- c. The facility operates under by-laws acceptable to the ethical standards of its county and state societies and agrees to provide medical staff functions comparable in quality to those prevailing in the usual institutions.

Dr. Bieleck: "Mr. Speaker, I move the adoption of the Report of Reference Committee No. V as amended."

It was adopted as amended.

"This concludes the report of Reference Committee No. V."

The Speaker asked for any unfinished business that may need to be brought before the House. There was none.

The Speaker commended and thanked Dr. Richard S. Hodes, Representative from Tampa, for taking the time during such a busy time of the Florida Legislature to attend our annual meeting.

There was a warm round of applause for Dr. Hodes.

## Elections

### President-Elect

The Speaker opened the floor for nominations for the office of President-Elect of the Association for 1973-1974.

Dr. Sanford Mullen, Duval County, placed in nomination the name of Dr. Thad Moseley of Jacksonville.

Dr. Moseley's nomination was seconded by Dr. Nelson H. Kraeft, Leon County; Dr. William M. Straight, Dade County; and Dr. David D. Hill, Hillsborough County.

Dr. Philip B. Phillips, Escambia County, placed in nomination the name of Dr. William M. C. Wilhoit of Pensacola.

Dr. Wilhoit's nomination was seconded by Dr. Jack A. MaCris, Pinellas County; Dr. James J. Hutson, Dade County; and Dr. Edward G. Haskell, Leon County.

Nominations were closed and upon secret written ballot Dr. Moseley was elected and requested to come to the podium.

Dr. Wilhoit thanked the delegates and requested that the ballot for Dr. Moseley be unanimous.

Dr. Moseley: "Gentlemen, I thank you. You never know whether an honor of this sort makes you happy or makes you sad because you defeat someone who is a gentleman. Merrill, thank you very much.

"None of us change the course of FMA, we just influence it, but I do promise you that in the year to come I will do my best to influence it in that direction which you, the members of the FMA, tell me you wish to go. I will try, I will need your help, please let me know what you think and gentlemen, I sincerely thank you for the honor you have bestowed upon me."

### Vice President

The floor was opened for nominations for the office of Vice President.

Dr. James C. Hewitt, Hillsborough County, placed in nomination the name of Dr. Frederick C. Andrews of Mount Dora.

Dr. Andrews' nomination was seconded by Dr. Emmet F. Ferguson Jr. of Duval County; Dr. Thomas M. L. Quehl, Pinellas County, and Dr. Thomas D. Weaver of Lake County.

Nominations were closed and a unanimous ballot cast for Dr. Andrews.



President-Elect Thad Moseley, M.D., of Jacksonville (left) is being escorted to the rostrum by John A. Rush Jr., M.D., of the Duval delegation.



Frederick C. Andrews, M.D., Mt. Dora accepts his nomination of FMA Vice President.

### Speaker of the House

The floor was opened for nominations for the office of Speaker of the House.

Dr. Vincent Corso, Dade County, placed in nomination the name of Dr. Franklin J. Evans, Coral Gables.

Dr. Evans' nomination was seconded by Dr. Leonard E. Masters of Jacksonville.

Nominations were closed and a unanimous ballot cast for Dr. Evans.

### Vice Speaker

Nominations for the office of Vice Speaker were called for.

Dr. Edward W. Stoner of Orange County placed in nomination the name of Dr. Louis C. Murray of Orlando.

Dr. Murray's nomination was seconded by Dr. Irving M. Essrig, Hillsborough County; Dr. Leo M. Wachtel, Duval County; Dr. Luis M. Perez, Seminole County; and Dr. Joseph H. Davis, Dade County.

Nominations were closed and a unanimous ballot cast for Dr. Murray.

### Secretary and Treasurer

The Speaker called for nominations for the offices of Secretary and Treasurer.

Dr. John Rush, Duval County, placed in nomination the name of Dr. James W. Walker of Jacksonville.

Dr. Walker's nomination was seconded by Dr. Walter Jones, Dade County; Dr. Joseph G. Matthews, Orange County; Dr. Charles J. Kahn, Escambia County.

Nominations were closed and a unanimous ballot cast for Dr. Walker.

Dr. Andrews thanked the House for placing their confidence in him as Vice President and stated that he would do his best to express their desires. He then introduced his wife, Gloria.

Dr. Evans expressed his gratitude for his renomination and introduced his wife, Jean, and his daughter, Holly, and stepmother.

### AMA Delegates

The Speaker called for nominations for election of AMA Delegates and Alternates for two-year terms beginning January 1, 1974 and expiring December 31, 1975.

The motion was made from the floor to re-elect the entire slate of delegates by acclamation for the entire two-year term.

The motion was seconded and carried.

The delegates are as follows:

Delegate	Dr. Robert E. Zellner	Seat No. 1
Alternate	Dr. James T. Cook	
Delegate	Dr. Burns A. Dobbins	Seat No. 4
Alternate	Dr. Eugene G. Peek Jr.	
Delegate	Dr. Rufus K. Broadaway	
Alternate	Dr. Thomas B. Thames	

Dr. Clyde Collins asked for a standing vote of confidence for the AMA Delegates.

### Judicial Council

The Speaker referred the House to the report of the Board of Governors, in which it nominated Dr. John J. Cheledon, Daytona Beach, for re-election to the Judicial Council for a five-year term to expire in 1978.

Motion carried that Dr. Cheleden be re-elected to membership on the Judicial Council.



## Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report, and asked for additional nominations from the floor.

There were no additional nominations; the nominees submitted by the Board of Governors were unanimously elected to the Committee on Membership and Discipline (See report of Board of Governors, page 48.)

## Installation of Officers

Dr. Dean expressed his appreciation for the vote of confidence given him during the past year and introduced his wife, Polly; son, Bryson; daughter, Julie; sister, Dee Jones; brother-in-law, Dr. Wardlaw Jones; and his secretary, Mary Louise Merrill.

Dr. Dean presented the President's Gavel to Dr. Von Thron, incoming President.

Mrs. Mary Ann Mathews: "As the new President of the Woman's Auxiliary to the Florida Medical Association, I would like to present Joe Von Thron with this single red rose and would



Having just been installed as FMA President, Dr. Von Thron thanks the House.



Retiring President Dean presents the President's plaque to incoming President Von Thron.



Newly installed FMA President, Dr. Von Thron presents Dr. Dean with the Past President's Pin.



Mrs. Dean proudly accepts the painting of her husband.

like for him to know that we will work with him with love this coming year."

Dr. Dean presented the President's plaque to Dr. Von Thron.

After a brief summary of Dr. Dean's accomplishments over the past year, Dr. Von Thron presented the past president's pin to Dr. Dean.

Dr. Von Thron then asked Dr. Dean's son and daughter to accompany Mrs. Dean to the podium where he presented Dr. Dean's portrait to "this most gracious lady."

Dr. Von Thron introduced the members of the Board of Governors and the Council Chair-

men for the coming year and introduced his wife, Jane, and children, Jim, Judy, John and Joan.

Dr. Von Thron announced the Board meeting in the Pan American Room immediately upon adjournment of the House.

Dr. Von Thron: "I want you to know again that I will do my utmost to serve you well."

Dr. Evans, Speaker of the House, thanked everyone for their very wonderful cooperation during this session of the House.

He then called on Dr. Jack Q. Cleveland, past President, to give the benediction.

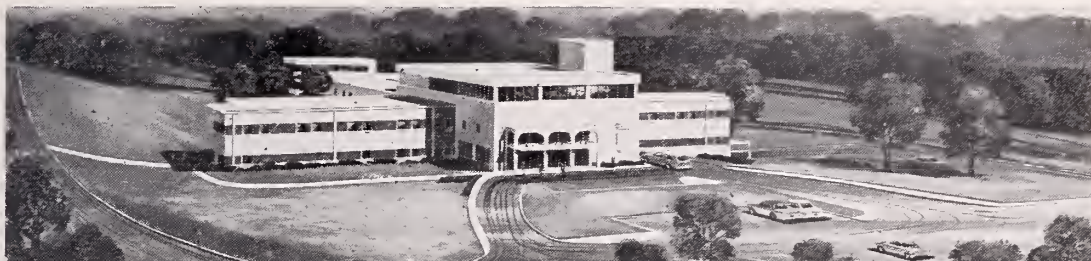
The 1973 House of Delegates adjourned at 12:40 p.m.

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## Editorials

### PSRO or Nothing?

Doctors throughout most of the country currently are presenting a facade of willingness to cooperate with the government. Leaders of organized medicine appear unsure as to what is the right thing, but they are trying hard to avoid doing the wrong thing. The main body of the profession is even more confused. Quietly resentful, a large part is aware that the politicians are closing a destructive vice over the practice of good medicine. Doctors can see no really tolerable course open to them in either direction.

We are faced with a dichotomy, a possible total break, a schism because lacking is a unified course that permits realistic freedom of action. Perhaps an all out break is unnecessary. Perhaps there is a synthesis, an ethical selection of ethical alternatives.

To change this contentious scene, we must first examine facts that cannot be changed, facts all of us, regardless of our convictions, must face.

#### FACT NO. 1: GOVERNMENT INTRUSION

The first fact that cannot be eliminated is the major intrusion of government into the care of the sick. We can wish to eliminate it completely, we can dream up arguments that prove to us that elimination is the best course, but to believe it possible of achievement in today's political structure is totally unrealistic.

#### FACT NO. 2: GOVERNMENT CONTROL

So, with the inescapability of the first fact accepted, we must look at the second reality—in providing the money for care of the sick, the government will exercise a large measure of control over those receiving it.

As a matter of rational thinking, we must admit that this is the way it has to be. There is no way for gross misuse to be minimized except by a

measure of government control. No matter how altruistic we like to consider the members of our profession, we are all human beings, some with great weakness, all with some weakness, and every honest one among us will admit to thoughts that his judgment about management is at times swayed by whether or not the government is paying the bill. The rare bad physician, who apparently functions without conscience, should be dealt with by mechanisms more effective than have been in use up to the present. We have all been embarrassed at knowledge of such miscreants, but our embarrassment has not produced a method of keeping their feet out of the trough of government funds. Justifiably, perhaps, in the past, we have made no great thing of the small number of bad actors. For good reasons we have taken the attitude that people should retain the freedom to be human. Most fringe doctors, those who do some things we would not do, were, first of all, not all bad, and, secondly, they were doing these things to people who were perfectly free to obtain care wherever they pleased, and who would prefer to keep it that way. We did not like this, but believed that government action was a poor solution.

Getting government "goodies" into the scene has to change it. The patient with free choice can now exercise his freedom at public expense and this is obviously wrong. So the second fact is the inescapability of government control.

#### FACT NO. 3: PROFESSIONAL EVALUATION

Thirdly, regardless of our "escape mechanism" in refusing to take assignments, our Medicare patients can be refused Part B benefits on any arbitrary political basis dreamed up by the men in control. Further, hospital bill coverage by Medicare (Part A) is absolutely subject to government

decision regarding individual doctors. So, if we wish our patients to receive the large sized benefits of Medicare coverage, we must acknowledge and accept professional evaluation in some form acceptable to the government.

#### FACT NO. 4: INDEMNIFIED BENEFITS

The fourth major fact is that there is no fair and businesslike way for Medicare or insurance companies to pay benefits to a third party except on an indemnity basis. On any basis less precise, there are too many uncontrollable ways to finagle. The basis of "usual and customary" is too wide open, despite the fact that it sounds altruistic and decent. Its success (and it is not a gross failure thus far) has resulted from the truly large measure of good faith action by doctors. This is the same good faith that resulted in most of us taking care of many charity cases in years past and making nothing of it. But, in rather short order, when the government becomes liable, charity and altruism flee the scene.

Any one of us who has been "building his profile" on the computer, showing a fee scale 20% less than the doctor down the street, is going to consider it grossly unfair for the government to allow 20% more for that man's services than our own. And there is no answer. When the patient pays that doctor a larger fee, he has a choice. He can pay the higher fee to see the doctor he prefers, instead of buying some other commodity. The "usual and customary" proponents make the fine-sounding point that "Medicare patients deserve the same treatment as anyone else going to that doctor." This forces the government (or insurance company) to take the attitude that the doctor down the street is selling a better service simply because he charges more. We all know that this is widely fallacious.

We need to keep the market open, and let the doctor charge whatever he pleases, as long as the excessive fee doesn't come from the government. An indemnity schedule that varies geographically might be reasonable, but no other variable in the use of public funds can be fair.

#### IMPLICATIONS

Intrusion of these facts into the scene potentially and actually destroys some important facets of the practice of medicine. Can we do anything to prevent this destruction? Perhaps. We tend to think in such total terms that we forget we are

not indeed fully socialized. Some highly responsible and excellent members of our profession believe that we must now make a dramatic stand; perhaps turn back the dragon; and that this is an all or nothing situation.

Certainly, there are some doctors who will not care, who will be willing to accept these facts and who will silently subject their entire practice to the political manipulations. There are a good many who would at least agree to government control of hospital expenditures for Medicare patients and for professional evaluation of themselves if it be done fairly and in good faith by their true peers. Properly carried out, peer review is ordinarily objectionable only to the incompetent, whom the rest of us really should not wish to protect anyway.

But, peer review does have some deficiencies. Emotions always cloud the reviewing scene in varying degree. Also, the reviewers have no really valid way to measure the good accomplished by any one physician. We can live with such defects only if there be modifying elements, such as a clearly free-market doctor-patient relationship, in which the doctor who accepts peer review can treat patients in any category. His patients can receive Medicare (or insurance) indemnification; the doctor can insist on a higher fee if he wishes, and there is no concern to the government or insurance company that an advantage is being taken by anybody. This can preserve much of the present incentive to practice to the best of one's ability.

#### DOCTORS OF PRINCIPLE

But, there is another group of doctors who must be included in our thinking; the very large number of fine physicians who practice sound medicine and who cannot in good conscience accept this measure of collectivism. So, we must find a legitimate relationship in our profession for those who feel they must adhere to the old principles in spite of everything. There does not have to be total dichotomy, only a distinction regarding the disbursement of government funds.

This cannot be hedged. These doctors must really be prepared to go all the way and anticipate participation in no medical activity using government funds.

This could be a very desirable and productive area. We have watched the geometric escalation of all medical expenses just as we predicted would occur with intrusion of the government. It seems

reasonable, and an attractive challenge, for the "doctors of principle" to show how much better and less costly they can make a purely private practice. It is simply necessary that organized medicine help protect them from being mistreated or dealt with unfairly just because they refuse to accept government manipulations. The implications of this thought are tremendous.

There is one important hazard that the "doctors of principle" must find an effective answer for—they must avoid being lumped publicly or professionally with the incompetents and charlatans. For example, they must not jump automatically to the defense of the victims weeded out by peer review.

Many unbelievable gimmicks being forced upon us to "control costs" are truly necessary results of the direction taken by the government in the medical field. They are inevitable measures to compensate for the ugly consequences that we predicted when we were fighting the inception of these laws, from Kerr-Mills on down.

Now that these things are coming about, the government must try to modify expenses in these appalling ways, or else back out of the scene. Much as we would wish it, there is no chance of the "backing out." We can only expect more and more constrictions to the practice of good medicine as the government gets deeper and deeper into the field. This will leave more and more advantage to the "doctors of principle."

The public generally will not be aware of how much worse off it is medically, but if we keep a freedom of choice reasonably available to the individual, this will be our major success.

## Summary

In summary, we must clear away the brush and make our adjustment to four important facts:

1. Major intrusion of government into care of the sick and the irreversibility of this trend.
2. The inevitability of political control over the expenditure of government money.
3. Doctors must accept professional evaluation if they or their patients receive benefits of any government money.
4. Government benefits can be fair only on an indemnity basis.

We must recognize a division of our profession into two ethical components. One group will treat patients under government benefit conditions and accept the consequences. The other will stand clear of government intrusion and accept as necessary any monetary disadvantages as "doctors of principle." We must maintain fairness for both groups and keep a free path for a doctor to shift ethically from one to the other.

In such a reality context, the ultimate limit on government's manipulations to force its mistakes into acceptability will be the fair competition from the "doctors of principle."

If we all face the scene honestly, we can function as members of the same organization, aimed at dealing with these facts as they are, trying to accomplish the best care of the sick, but accepting two ethical pathways to follow.

In the absence of dictatorship, the most desirable result will then ultimately prevail.

WILLARD E. MANRY JR., M.D.

► P. O. Box 1140, Lake Wales 33853.

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I wonder

What would happen if each drop  
of rain refused to fall,  
or every sunbeam ceased to shine  
because it was too small?  
What would happen if each day  
we choose to leave undone  
an act of kindness just because  
it was a little one?

Esther Thom  
Worthington, Minn.



# Does My Smoking Bother You?

## It Doesn't Bother Me as Much as it is Going to Bother You!

Authorities agree<sup>1</sup> that smokers of cigarettes have an increased risk of disability, illness, and death from a number of smoking-related diseases including cancer of the lung, larynx and lip, chronic bronchitis and emphysema, coronary heart disease, and peptic ulcer. Elimination of cigarette smoking is, in fact, the single most important health measure available today for the prevention of diseases and premature deaths<sup>2</sup> in Florida and the United States.

What about the effects of passive inhalation of air pollution due to tobacco smokers? Forty-two cigarettes smoked in a 10' x 12' x 14' unventilated room, within a 16 to 18 minute period, produced up to 50 ppm carbon monoxide.<sup>3</sup> Exposure to this level for 27 to 90 minutes may alter auditory discrimination, visual acuity, and the ability to distinguish relative brightness. The amount absorbed depends upon the quantity of smoke produced, depth of the smokers' inhalation, and proximity to the smokers.

One investigator, reporting<sup>4</sup> on three individuals with varying carbon monoxide exposure, observed that 10% carboxyhemoglobin (COHb) was associated with increased response time for taillight discrimination and increased variance in distance estimation. With a COHb saturation of 5%, patients with coronary heart disease showed a decrease in arterial and mixed venous oxygen tension.

The subjective responses<sup>5</sup> of two groups of nonsmokers to tobacco smoke exposure was recently studied. In one-sixth of these patients a positive skin test to tobacco extract was found, but only a few patients were seen with objective symptoms which would be traced to tobacco smoke. The other group of 250 patients had no history of allergy and was studied by questionnaire only. Eye irritation, nasal symptoms, headache, and cough were common in both groups.

The authority concluded that these effects of tobacco smoke were irritative rather than allergenic in origin. The data presented in this study demonstrate that tobacco smoke can contribute to the discomfort of many individuals; they do not rule out a possible contribution from allergenic reactions.

The nonsmoker experiences more nasal and ocular irritation as compared with the smoker exposed to similar amounts of smoke.

Tobacco smoke can contribute to the discomfort of many individuals. It exerts complex pharmacologic, irritative, and allergenic effects, the clinical manifestations of which may be indistinguishable from one another.

Exposure to tobacco smoke may produce exacerbation of allergenic symptoms in nonsmokers who are suffering from allergies of diverse causes. Persons with a history of allergenic reactions usually show more nasal symptoms, headache, cough and wheezing.

Isn't it about time that the nonsmoker voiced his views and made his own decisions as to what and how much personal pollution he is willing to tolerate from the cigarettes of others?

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JAMES E. FULGHUM, M.D.  
RONALD B. MITCHELL, Ph.D.

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# Cigarettes and Death Certificates

All of us are well aware of the role cigarette smoking plays in the causation of pulmonary emphysema and squamous cell carcinoma of the lungs. Most of us also realize the aggravating effects of cigarette smoking upon coronary ischemic heart disease. For years we have neglected to mention tobacco on certificates of death except under the most unusual of circumstances.

Physicians are expected to render a clinical judgment as to the causative factors of death when a certificate is completed. There is no reason why we should continue to omit the most significant causative factor in the production of pulmonary emphysema and squamous cell carcinoma of the lungs when we certify. Certainly the use of tobacco is the major underlying causative factor in the above two diseases.

The collection of accurate final statistics has always been a function of the Division of Health. It would be of great service if every physician in the State of Florida were to receive a directive from the Division of Health with a request that

cigarette smoking or tobacco use be specifically mentioned on the death certificate when, in the clinical judgment of the certifier, this was a factor when death was caused by pulmonary emphysema or squamous cell carcinoma of the lung or other smoking related diseases. An alternative would be a box to be checked off on the certificate which would designate whether or not the patient had been a heavy user of cigarettes. This would be simpler for the physician as it would require no additional judgment decision on his part in regard to the relationship of the death and cigarettes. Statistical analysis of the data so collected would, in the long run, accomplish the same desired purpose.

In the meantime, there is no reason why we physicians, on our own, could not begin to certify as has our colleague, Dr. Charles F. Tate.

JOSEPH H. DAVIS, M.D.

► Dr. Davis, Dade County Medical Examiner, Miami 33136.

Department of Health and Rehabilitative Services DIVISION OF HEALTH BUREAU OF VITAL STATISTICS										STATE FILE NO _____			
CERTIFICATE OF DEATH FLORIDA										REGISTRAR'S NO _____			
1 DECEASED—NAME FIRST MIDDLE LAST										2 SEX Male			
3 RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY)										4 AGE—LAST BIRTHDAY YEARS MONTHS DAYS 66		5 DATE OF BIRTH MONTH DAY YEAR May 5, 1906	
6 CITY, TOWN, OR LOCATION OF DEATH Miami										7a COUNTY OF DEATH Dade		7b DATE OF DEATH MONTH DAY YEAR January 9, 1973	
8 STATE OF BIRTH (IF NOT IN U.S.A.) NAME COUNTRY New York U.S.A.										9 MARITAL STATUS Married		10 SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)	
11 SOCIAL SECURITY NUMBER 103 12 3188 A										12 USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Barber		13 KIND OF BUSINESS OR INDUSTRY Barber Shop	
14 RESIDENCE—STATE COUNTY CITY, TOWN, OR LOCATION Florida Dade Miami										15 INSURE CITY LIMITS (SPECIFY YES OR NO) Yes		16 STREET AND NUMBER 5035 N.E. 2nd Avenue	
17 FATHER—NAME FIRST MIDDLE LAST MOTHER—MAIDEN NAME FIRST MIDDLE LAST										18 UNobtainable		19 UNobtainable	
20 INFORMANT—NAME FIRST MIDDLE LAST										21 MARITAL ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)		22	
23 PART I DEATH WAS CAUSED BY (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))										24		25	
(a) Acute respiratory insufficiency										(b) Bronchogenic carcinoma, squamous cell left		(c) Cigarette smoking	
26 PART II OTHER SIGNIFICANT CONDITIONS (CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I)										27		28	
29 PROBABLE ACCIDENT, SUICIDE, OR HOMICIDE, OR UNDETERMINED (Specify)										30 DATE OF INJURY MONTH DAY YEAR		31 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 1)	
32 INJURY AT WORK (SPECIFY YES OR NO)										33 PLACE OF INJURY AT HOME (FARM, TREE, FACTORY, OFFICE BLDG., ETC.) (SPECIFY)		34 LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)	
35 CERTIFICATION—PHYSICIAN										36 I ATTENDED THE DECEASED FROM		37 CERTIFICATION—MEDICAL EXAMINER OR CORONER (ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED)	
38 CERTIFIER—NAME (TYPE OR PRINT)										39 SIGNATURE		40 DEGREE OR TITLE	
41 CHARLES TATE, JR., M.D.										42 JMH		43 DATE SIGNED MONTH DAY YEAR 1/9/73	
44 MAILING ADDRESS—CERTIFIER										45 CITY OR TOWN		46 STATE	
47 1700 N.W. 10th Avenue										48 Miami		49 Dade	
50 BURIAL OR CREMATION REMOVAL (SPECIFY)										51 CEMETERY OR CREMATORY—NAME		52 LOCATION	
53 Burial										54 Dade Memorial Park		55 Rural	
56 DATE MONTH DAY YEAR										57 FUNERAL HOME—NAME AND ADDRESS		58 STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP	
59 Jan. 12, 1973										60 Lithgow F. Home		61 485 N.E. 54th Street, Miami Fla.	
62 FUNERAL DIRECTOR—SIGNATURE										63 REGISTRAR—SIGNATURE		64 DATE RECEIVED BY LOCAL HEALTH DEPT.	
65 Alexander Kolski										66 Elizabeth Everson		67 Jan. 11, 1973	

# Problems in Postgraduate Education

NICHOLAS S. PETKAS, M.D.

**Abstract:** Rapidly changing data and knowledge cause obsolescence to begin with graduation. Postgraduate training is expensive, relatively unavailable, time demanding and requires absence from one's area of practice. Decentralized, distance oriented, inexpensive, convenient, and highly effective collegiate instruction is now within the scope of present day technology.

A system of this nature is suggested in broad outline and this area is suggested as the most effective area for participation by a medically oriented governmental organization such as FRMP.

Regardless of the field, whether technical or nontechnical, as the student leaves the learning environment to assume responsibilities of full membership within the professional group he is the man admonished by his instructors that his education has not ended. That which has gone before prepares him to meet future obligations.

All fields suffer from continuing obsolescence and certainly no more than present day, highly technical, highly research-oriented medicine. The physician who has completed his formal education and is embarking in practice begins to become obsolete, in a sense, the day he leaves the university or his residency. His greatest effort must be expended in keeping abreast of his special interest as it develops about him.

### Problems

This brings us to problems in postgraduate education. Although these may be listed in various orders of priority, time, distance and expense would be included.

Physicians are in constant demand with heavy requirements placed on their time. In addition to the professional, there are personal demands, those of family life, rearing children, actual day-to-day economics of making a living, supporting offices and staffs. Physicians are also husbands, fathers, church members, citizens, people necessarily involved in earning a living and paying bills.

Traditional postgraduate education has taken the form of seminars, conventions and courses usually presented in some central locale which necessitates travel and absence from patients and practice. This places an added burden of expense which has to be reckoned with in a professional field.

A solution offered to this problem in the past has been the "circuit riding" professor. One would be naive indeed to assume that the professor of medicine is any less committed to the problems of time and expense. The circuit rider usually is required to present his lecture at the worst possible time, namely, working hours when those who would profit from his instruction are busily engaged in practicing medicine.

### Desirable Attributes

We must then define the desirable attributes of any postgraduate educational system. These may be listed. (1) Minimal demands upon time. It should fit into the busy life of the man in medicine. There should be sufficient flexibility. The course may be scheduled simultaneously with his other responsibilities or, as in some prepackaged postgraduate programs, attended to in the little free time available, i.e., cassettes and audio-visual aids usable in the home, automobile or office. (2) Timely. It should deal primarily with current evolving data as it becomes applicable in the daily practice of medicine. (3) Availability. It should be readily available. This would avoid cumbersome preregistration attendance scheduling which requires prolonged waiting. (4) Inexpensive. It should be relatively inexpensive. Although government allows deduction of expenses incurred while pursuing one's field of knowledge, still the expense is necessarily deleted from the everyday operating funds of a family unit. (5) Minimal travel requirements. It is certainly seen that postgraduate education which requires absence from work and family environment will be poorly utilized. Postgraduate education should be applicable in a person's "neighborhood," thus requiring minimal disturbance of his daily work routine.

Dr. Petkas is District Director, Area 9, Florida Regional Medical Program.



## Concept of Distance Communication

A review of available educational techniques will continue to return the reviewer to a concept which includes distance communication media. Certainly the only method whereby physicians from widely divergent areas may be gathered together effectively would be one wherein the instructor's knowledge and presence could be dispersed over hundreds of miles, maintaining some semblance of availability for immediate discussion and question.

What is being called for is not a bold experiment in learning and in no way constitutes groundbreaking research. It is nothing more than an attempt to correlate currently existing technology with existing problems. This concept has been tried in many places and currently is being successfully pursued in several parts of the country.

Programs in existence include the Wisconsin Telephone-Radio Conferences sponsored by the University of Wisconsin School of Medicine and the Telephone Lecture Network Program utilizing the medical center in Buffalo, New York. The Wisconsin program has well over 25,000 hours of experience and has available not only expertise and factual data but also a considerable library of cassettes of programmed lectures. The same can be said for the program in New York State. These programs are being actively pursued, involve hundreds of people, and offer preplanned lectures in all fields of medicine, ranging from physicians through ancillary personnel such as nursing, medical and laboratory technologists and food handlers.

These programs include a definite flexibility and satisfy the concept of immediacy. Although lectures are carried on by telephone or radio transmission, programs can be "live," allowing two-way discussion. A program may form the basis for hospital in-service education, thus allowing constant "updating" of new developments, procedures and equipment. The factor of flexibility is so outstanding that journal clubs meet through distance communication and carry on regular discussions even though participants may be separated by many miles.

The applicability of this program is unlimited. It could be fitted into a hospital education program and, if made synchronous with the regular staff meeting, which also carry the requirements of continuing education, live case presentations could be made and discussions carried out with

professors of medicine who may be many miles away. These teachers would be unencumbered by problems of time, expense and absence.

As another example of the application of this concept in education, one need only consider the large libraries in readily available taped cassette form which would become available as a positive "side effect." These cassettes would entail an absolute minimum of expense in distribution and utilization and could carry their own weight of expense by being distributed through subscription.

## Future Applications of This Concept

We are living in an electronically marvelous world, a fact which can hardly escape the attention of any knowledgeable person. That the marvels to be available in the future will become compounded is not only a hope but an average expectation. It is possible that postgraduate education will become generally available since transmission of visual and auditory lecture material is well within the scope of present technology. The concept of distance communication is not limited to voice transmission alone. The highest form of postgraduate education would be that wherein an individual within the confines of his own office or home may be able to participate in seminars, see and hear lectures by world renowned teachers and researchers, tune in visually and audibly on panel discussions by participants separated by half a world, and even to store all this in readily available pocket size form for later review.

## Cost of Telelecture Network

The scope of this presentation is not intended to include a detailed discussion of the cost and support of a sophisticated distance communication media educational system. Those programs which have been in existence for several years indicate that the cost is inversely proportional to the utilization. In well accepted programs with widespread participation, cost per student estimates range to well below that required to attend a popular movie.

In such a system would, of necessity, not only cross state and national boundaries, but would conceivably cross international boundaries, such a system would best be organized by, and, would of necessity, require the participation of medically-oriented federal organizations such as Regional Medical Programs working in consort with local medical organizations and teaching institutions.

► Dr. Petkas, 2250 Palm Beach Lakes Boulevard, West Palm Beach 33401.

## **Medical News**

### **Dr. Stetson Named to Cancer Group**

The National Cancer Institute has appointed Chandler A. Stetson, M.D., Dean of the University of Florida College of Medicine, to a committee to review research of the NCI Special Virus Cancer Program and to make recommendations for future virus-cancer research.

### **Cancer Conference at Bal Harbour**

The American Cancer Society's Second National Conference on Cancer of the Colon and Rectum will be held at the Americana Hotel in Bal Harbour, September 27-29, 1973.

Sessions are open to all members of the medical and related health professions. There is no registration fee, but pre-registration is requested.

Information may be obtained by writing to: Sidney L. Arje, M.D., American Cancer Society, 219 East 42nd Street, New York, New York 10017.

### **ACA Admits Four State M.D.'s**

The American College of Anesthesiologists has certified four Florida physicians as fellows.

They are: M. Prudence Butt, M.D., Coconut Grove; Andrew D. Rackstein, M.D., Clearwater; Dennis J. Rudzinski, M.D., Miami; and James Routon, M.D., Pensacola.

### **New Editor for Southern Journal**

Harris D. Riley Jr., M.D., of Oklahoma City, Okla., has been named editor of the *Southern Medical Journal*, the scientific publication of the Southern Medical Association.

Dr. Riley is Professor of Pediatrics and head of the Department of Pediatrics at the University of Oklahoma College of Medicine. He previously served as pediatric editor and assistant and associate editor of the monthly publication.

### **Seminar in Gastroenterology**

The University of Miami School of Medicine will conduct a Postgraduate Seminar in Gastroenterology at the Americana Hotel on Miami Beach, September 20-23.

There will be a registration fee of \$125. The American Academy of Family Physicians has been petitioned to approve the seminar for 16 credit hours.

Information may be obtained from William Bouck, Management International, Inc., 1200 N.W. 10th Avenue, Miami, Fla. 33136.

### **Fertility Society Elects Dr. Lay**

Coy Lay, M.D., of Lakeland, has been named President-Elect of the American Fertility Society.

**Because you  
practice  
medicine in the  
Sunshine State...**



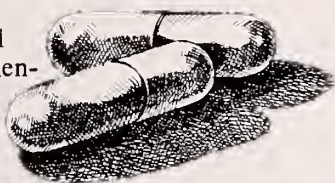


**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition.

Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis**

# **adjunctive Librax®**



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110



## Woman's Auxiliary

### Fore Team Play—All the Way

Dear Doctor:

Summer vacations ahead . . . and I'm remembering all those lovely courses your wives have invited me to try when my term as Auxiliary president expired. If you see *and hear* an unfamiliar lady golfer wailing over a missed shot, it may just be this past president. (I promise to replace my divots and rake the traps, being particularly adept at the latter!).

Before succumbing to the lure of the wide fairways and lush greens there remains this final letter to you. You may detect a note of nostalgia, for although I've found the composition and deadlines painful, I've thoroughly enjoyed the privilege of writing you about your wife and your Auxiliary.

And by the way, Doctor, you DO know how to make a girl feel *great*! The exhilaration of our successful convention hasn't worn completely away, and in accepting your kind words and congratulations I felt much like the captain of a winning team. This past year your Auxiliary displayed some great team effort, with many of your wives right in there chipping and putting all the way. (Some of her fairway shots were superb, too!).

Have you noticed I said "many of your wives"? We still have a **MEMBERSHIP HANDICAP** but many hours on the practice tee will bring more visible improvement next year. A more realistic membership quota to aim for and the organization of branch-type auxiliaries in more of our big city/county areas will add more members to the team. (Incidentally, over 300 of our members cannot belong to the national auxiliary, giving us one less delegate to represent and voice Florida's viewpoints.)

Nevertheless, you have an outstanding team, now nearing the 4,000 membership mark, and here's how they scored on the following holes . . . er, projects:

**AMA-ERF:** Surpassing last year's score seemed impossible but it happened. Over \$40,000 raised

via Auxiliary efforts and physician contributions. The most recent report showed that Florida's medical schools' grant distribution of these funds totaled over \$11,000.

**FAMEF:** Florida Auxiliary's own scholarship loan fund remained at even par this year. With many county auxiliaries establishing similar scholarship or scholarship/loan programs, only two state loans were requested, and six were repaid by grateful graduates.

**FMF:** Seafood and citrus sales, and the highly successful Mediterranean Tour netted your Florida Medical Foundation a double eagle! The 1972 Annual Art Show added some yardage to the fairway shot, as did the contributions from two counties, but that long putt from the fringe was worth over \$5,000 (the tour!). Even Arnie would be thrilled to make over \$6,500 on this one!

**Health Careers:** This could very well have been our disaster hole this year, except for the fine work and concentration of the chairman and some of our enthusiastic auxiliaries and their medical societies. The fairway has been narrowed (loss of auxiliary interest in some areas) and the bunkers are tricky and treacherous (split school sessions and lack of cooperation from some school officials). Your team kept the ball in the fairway and reached the green without difficulty, saving the par . . . in fact, the Health Careers Convention attended by over 200 really interested youths added excitement and encouragement . . . we *almost* made a bird!

**IHA:** There are many ways to play this one: This year hundreds of pounds of needed supplies went to stricken Nicaragua and other areas. The birdie shot came at Fall Conference when the IHA BAZAAR (sale of handmade articles, etc. donated by county auxiliaries) total of \$1,192 was realized. \$350 of this sum provided another year's scholarship for our Indian Child and the balance to Direct Relief for the people of Nicaragua.



**Communications:** Ground under construction here. Many months were spent re-designing a new fairway for publication of a state auxiliary newsletter. In March we tried it out, and one issue was published and mailed. (I haven't heard how we fared on this one, but we're hoping for at least a par!)

**Health Education Conference:** You heard about this many times during the year, and again at convention, and with good reason: (If *you* had a hole-in-one, we'd be hearing about it for a while!) Rules were relaxed somewhat to allow for outside assistance and the joint effort paid off handsomely, calling attention to the need for a comprehensive health education program for all of Florida's Youth. Everyone was watching, and our public relations soared. It pays to keep your eyes on the ball and follow through, and a follow-through letter went to well over 200 participants and auxiliary representatives in the final week of the legislative session. Doctor, you can tell your wife that a call just received from Tallahassee proves that their "follow-through" helped on this important health education legislation.

**Legislation:** Required steady concentration in the fairways, and beware of that bunker to the left marked "Chiropractic Issue." Your team concentrated on this hazard by appearing at Tallahassee on a most propitious day. With FMA Legislation Pro (Scotty Fraser) helping us to read the greens on this and other issues, how could we miss?

**Public Relations:** Your Auxiliary didn't exactly make the sports page, but in many areas we *did* get off the Society columns. News releases on our Health Education Conference received the widest

coverage ever, and county auxiliaries consider this has been *the year* for improved relations with the press. You can give the girls a birdie on th's one, with a special thanks to any of the medical society executive directors who may have helped.

Doctor, we have so many other areas I'd like to tell you about but space does not permit. In talking with you, I'm pleased to learn that you have become more knowledgeable about your state and county auxiliary, and that you're inviting more of us to serve on your own teams. I think we've proven our value on both state and county level.

The women of your Auxiliary thank *you*, for you have been our supporters and admirers, and with your continued guidance, next year's success story will necessitate a supplemental issue of your Journal!

With my best wishes to all of you, I remain most happily,

DR. JIM'S WIFE

MRS. JAMES J. (CATHERINE) DeVITO  
IMMEDIATE PAST PRESIDENT, WA/FMA

P.S. Even the captain of a winning team has some bad moments . . . a missed shot, or perhaps she's chosen the wrong iron. I've been fortunate beyond belief to have someone right at my side, who offered not consolation, but confident that my next shot would correct the error. My life partner of almost 25 years, he recently taught me what I know of the game I most enjoy . . . and miracle of miracles . . . he enjoys golfing with me. This letter would not be complete without giving him my thanks and my love.



Mrs. James J. DeVito, retiring Woman's Auxiliary President, presents newly elected President, Mrs. V. H. Mathews, with the gavel.



What's  
on your  
patient's  
face

**The lesions on his face may be solar/actinic — so-called “senile” keratoses...and they may be premalignant.**

## **Solar, actinic or senile keratoses**

These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



*Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electro-surgical procedures.*

## **Sequence of therapy/ selectivity of response**

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; the reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

## **Acceptable results**

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.



*Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% -FU cream. Reaction has subsided. Residual scarring not seen except for that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.*

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local — pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported — insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with non-metal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers — containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

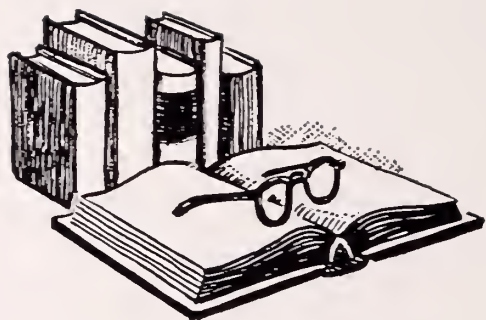
Cream, 25-Gm tubes — containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

**This patient's lesions  
were resolved with**

**Efudex®  
(fluorouracil)**  
**5% cream/solution**  
**...a Roche exclusive**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



## Book Reviews

**Synopsis of Pathology**, 8th edition by W. A. D. Anderson, M.D. and Thomas M. Scotti, M.D. 1076 Pp. 433 illustrations. Price \$13.95. St. Louis, The C. V. Mosby Company, 1972.

The 8th edition of "Little Anderson" follows the 7th by about 4 years. The same general format and chapter arrangement has been maintained except that references are now at the end of each chapter, rather than grouped together in a section at the end of the book, making them more readily accessible. The book has also grown by about 100 pages and will take up about  $\frac{1}{4}$  inch more on your bookshelf. A number of illustrations have been added and quite a few old, and occasionally obscure, photographs have been replaced with new, clearer ones of the same conditions. The three full color illustrations remain unchanged.

Most of the chapters have been expanded slightly and major expansions have occurred in the chapters on the cell and its behavior, inflammation and repair, water and electrolyte disturbances, growth disturbances and the chapter on the liver, gallbladder and pancreas. With the exception of the chapters on spirochetal, mycotic and protozan infections, bones and joints, and the nervous system where the major reductions have taken place, most other chapters have stayed at about the same length or only slightly increased.

You might reasonably ask why someone who is not a pathologist has chosen to review a pathology book. I feel mainly that the book is not written for the pathologist, but for the clinician who needs up-to-date ready reference in the general pathology field, and who may be unwilling to get an expensive comprehensive pathology book for his already overcrowded bookshelf. Anderson and Scotti's "Synopsis of Pathology" fills this requirement well.

LAWRENCE H. JACOBSON, M.D.  
MIAMI BEACH

**Gastroesophageal Reflux and Hiatal Hernia**, edited by David F. Skinner, M.D., Ronald H. R. Belsey, M.S., F.R.C.S., Thomas R. Hendrix, M.D. and George D. Zuidema, M.D. Pp. 208. Price not stated. Boston, Little, Brown and Company, 1972.

This volume comes from Johns Hopkins School of Medicine where there has been considerable interest and research in physiology of the lower esophagus. Nine authors collaborated to produce this book. Frankly, I was somewhat disappointed at the overall results. For example, I eagerly searched the pages for figures which showed their relative frequency of medical versus surgical treatment of hiatus hernia and esophageal reflux; however, instead I found the statement to the effect that surgical treatment was indicated only in the small hiatal hernia after good medical treatment had been tried for at least six months. They recommend surgical treatment for all large hiatal herniae.

The information given is good, and, for the most part, accurate. The virtue of this book is that it collects in one volume, with a complete set of references, information which has been, up to now, available only through a fairly extensive literature search. This volume may be useful to students and house officers.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Loving and Curing the Neurotic** by Anna A. Ter-ruwe and Conrad W. Baars. New Rochelle, N.Y., Arlington House Press, 1972.

Rarely in a man's life there comes along some accident, a woman, an experience, a leader, a book, that literally sets him on fire. This happy circumstance fills a gap, a need, a hunger that leaves him forever changed in himself, and in his dealings with others. Such, in one man's life at least, is the present book.



Dr. Terruwe is unhappy with the present state of psychiatry in the world. She lays her blame at the door, not of Sigmund Freud, but rather those followers or enemies of Freud who have apotheosized his work or else ruled it completely out of court and thus have frozen it into a closed-end, unchanging and unyielding system.

She says Freud was an accurate and scientific observer. For this, and the personally painful pioneering he did in the area of emotional disease, the world will always be in his debt. The conclusions he drew from his observations, she feels, were sometimes in error; and the system which he built from these ideas and conclusions was unsupportable and unverifiable.

Accordingly, on the rational psychology of Aristotle and Thomas Aquinas, she has constructed a love-oriented, Judeo-Christian psychology and psychiatry which is understandable, logical and verifiable. The religious man who studies this book will find his questions answered, his prejudices supported with facts, and his needs fulfilled. Once read and understood, this book makes a man a better man, a better physician, a better father, a better husband, a better human being.

The key to this work lies in understanding the theory of the appetites. There are two sensory appetites, the pleasure appetite (which is the same as Freud's libido), and the utility appetite which serves the pleasure appetite and procures those means which serve it. In the normal individual the pleasure appetite dominates, and therefore the person leads a joyful and well-adjusted life. In the neurotic, as the result of conflict, there is repression of normal joyful or desiring emotions and a resulting unhappiness. The utility appetite is also hypertrophied and the patient becomes pragmatic or utilitarian in behavior. Also there are exaggerated and inappropriate anger, hope, courage, fear or despair; the patient thus becomes reactively and spontaneously frustrated, obsessed, compulsive, anxious or depressed. Tension then is discharged by conversion symptoms by displacement into bodily psychophysiological reactions.

The phenomenology of neurosis is elucidated beautifully in this book and a map for understanding the neurotic clearly drawn out. From understanding, the authors imply one can go on to loving and then curing. For that person whose prejudices fit it and complement it, this particular work is very highly recommended.

J. E. BALTHROP, M.D.  
PENSACOLA

## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Your Prostate** by Robert L. Rowman, M.D. and Paul Gillette, Ph.D. Pp. 147. Illustrated. Price \$5.95. Garden City, N.Y., Doubleday and Company, Inc., 1973.

**We Mainline Dreams, The Odyssey House Story** by Judianne Densen-Geber, J.D., M.D., Pp. 421. Illustrated. Price \$9.95. Garden City, N.Y., Doubleday and Company, Inc., 1973.

**Vasectomy, Sex, and Parenthood** by Norman Fleishman and Peter L. Dixon. Pp. 128. Price \$5.95. New York, Doubleday and Company, Inc., 1973.

**Renal Disease in Childhood** by John A. James, M.B. Pp. 377. 116 Illustrations. Price \$23.50. St. Louis, The C. V. Mosby Company, 1972.

**Family Planning Education, Parenthood and Social Disease Control** by Charles William Hubbard, B.S., M.P.H. Pp. 173. 48 Illustrations. Price \$3.95. St. Louis, The C. V. Mosby Company, 1973.

**Correlative Neuroanatomy and Functional Neurology** by Joseph G. Chusid, M.D. Pp. 429. Illustrated. Los Altos, Calif., Lange Medical Publications, 1973.

**Handbook of Pediatrics** by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. Pp. 693. Price \$6.50. Los Altos, California, Lange Medical Publications, 1973.

**Readings in Family Planning** by Donald V. McCalister, Ph.D., Victor Thiessen, Ph.D. and Margaret McDermott, Ph.D. Pp. 256. Price \$6.50. St. Louis, The C. V. Mosby Company, 1973.

**Lithium in Medicine** edited by Joseph Mendels and Steven K. Secunda. Pp. 211. Price \$12.50. New York, Gordon and Breach Science Publishers, 1973.

**The Power and the Frailty** by Jean Hamburger. Pp. 140. Price \$4.95. New York, Macmillan Publishing Co., Inc., 1973.

## MEETINGS

National and Regional  
Meetings Held in Florida

### SEPTEMBER

- 27-29 National Conference on Cancer of the Colon and Rectum, sponsored by American Cancer Society, Americana Hotel, Miami Beach. Info.: Sidney L. Arje, M.D. American Cancer Society, 219 East 42nd Street, New York 10017.

### OCTOBER

- 1- 5 American Association for Laboratory Animal Science, Americana Hotel, Miami Beach. Exec. Sec.: Mr. Joseph Garvey, 2317 West Jefferson Street, Joliet, Illinois 60435.
- 11-13 American Society for Colposcopy and Colpomicroscopy, Sonesta Beach Hotel, Key Biscayne. Pro. Dir.: Adolfo C. Corzo, Symposia International, P. O. Box 580, Tujunga, Calif. 91042.
- 20-21 American Association for Hand Surgery, Diplomat Hotel, Hollywood. Sec.: Kim K. Lie, M.D., 27500 Hoover Road, Warren, Michigan 48093.
- 21-26 American Society of Maxillofacial Surgeons, Diplomat Resorts, Hollywood. Sec.-Treas.: Samuel Shatkin, M.D., 50 High Street, Buffalo, N.Y. 14203.
- 21-26 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Hollywood. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

### NOVEMBER

- 5- 9 Gerontological Society, Miami Beach. Exec. Dir.: Mr. Edwin Kaskowitz, One DuPont Circle, Washington, D. C. 20036.
- 7-10 American Medical Women's Association, Palm Beach. Exec. Dir.: Mrs. Gertrude Conroy, 1740 Broadway, New York 10019.
- 11-16 American Association of Blood Banks, Miami Beach. Office Mgr.: Miss Lois J. James, 1828 "L" Street, N.W., Washington, D. C. 20036.

1974

### JANUARY

- 19-23 American Academy of Allergy, Miami Beach. Exec. Sec.: Mr. James O. Kelley, 225 East Michigan Street, Milwaukee, Wisconsin 53202.

# Rondomycin<sup>®</sup>

## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE:** **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea:** In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i d, for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** "Rondomycin" (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



# Florida Medical Association

## Officers, Councils and Committees

### 1973-1974

#### OFFICERS

JOSEPH C. VON THRON, M.D., President .....	Cocoa Beach
THAD MOSELEY, M.D., President-Elect .....	Jacksonville
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS	
				Associate	Active
<b>Alachua</b> *Bradford, Gilchrist, Union	George H. Miller Jr., Gainesville	David F. Pawliger, Gainesville	2nd Tues.	79	206
<b>Bay</b>	Henry C. Smallwood, Panama City	Sidney A. Daffin III, Panama City	1st Tues.	—	44
<b>Brevard</b>	Edwin E. Hadden, Melbourne	Curtis G. Wherry, Titusville	2nd Tues.	28	164
<b>Broward</b>	James B. Perry, Ft. Lauderdale	Anthony J. Vento, Ft. Lauderdale	4th Tues.	142	675
<b>Capital</b>	Jack W. MacDonald, Tallahassee	Robert N. Webster, Tallahassee	1st Mon.	38	108
<b>Charlotte</b>	Robert H. Shedd, Punta Gorda	Stephen R. Roddy, Charlotte Harbour	2nd Tues.	1	40
<b>Clay</b>	Arthur D. Thaeler, Penney Farms	E. Charlton Prather, Orange Park	4th Tues.	2	22
<b>Collier</b>	Fred A. Butler, Naples	Hugh P. Smith Jr., Naples	3rd Wed.	—	68
<b>Columbia</b>	J. I. Benefield, Lake City	Nilton A. Lima, Lake City	3rd Wed.	4	18
<b>Dade</b>	O. William Davenport, Miami	Charles A. Monnin, Miami	1st Tues.	377	1,975
<b>DeSoto-Hardee-Glades</b>	Alex F. Amadio, Bowling Green	Fausto D. Garcia, Wauchula	1st Tues.	6	16
<b>Duval</b>	John A. Rush Jr., Jacksonville	Guy T. Selander, Jacksonville	1st Tues.	28	563
<b>Escambia</b>	Theodore J. Marshall, Pensacola	Charles F. McConnell, Pensacola	2nd Tues.	25	165
<b>Franklin-Gulf</b>	John W. Hendrix, Port St. Joe	W. T. Weathering, Apalachicola	Last Wed.	—	5
<b>Highlands</b>	Walter C. Price, Sebring	John B. Neal, Lake Placid	3rd Mon.	3	30
<b>Hillsborough</b>	Louis E. Gimino, Tampa	John K. Petrakis, Tampa	1st Tues.	81	424
<b>Indian River</b>	John P. Gifford, Vero Beach	James G. Punches, Vero Beach	2nd Tues.	5	40
<b>Lake</b>	Thomas H. Nichols, Clermont	William W. Conner, Eustis	1st Wed.	—	51
<b>Lee</b>	Wallace L. Dawson, Cape Coral	Warren E. Hagen, Ft. Myers	3rd Mon.	18	102
<b>Madison</b>	Julian M. DuRant, Madison	A. F. Harrison, Madison	1st Tues.	—	5
<b>Manatee</b>	Robert C. White, Bradenton	Richard F. Wynkoop, Bradenton	2nd Tues.	7	88
<b>Marion</b> *Levy	David C. Albritton, Ocala	Thomas D. Guin, Ocala	3rd Tues.	10	51
<b>Martin</b>	Herman R. Moore, Key West	William M. Whitely, Key West	1st Thurs.	2	19
<b>Monroe</b>	Marshall E. Groover, Jacksonville	Farid Ullah, Ferdinandina Beach	3rd Thurs.	1	39
<b>Nassau</b> *Baker	Albert B. Russell, Ft. Walton Beach	M. Mark Rog, Ft. Walton Beach	3rd Tues.	1	38
<b>Okaloosa</b>	James F. Richards, Orlando	Franklin B. McKechnie, Orlando	3rd Wed.	121	448
<b>Orange</b>	Robert G. Wood, St. Cloud	James E. Oglesby, St. Cloud	3rd Wed.	—	9
<b>Osceola</b>	Curtis W. Cannon, West Palm Beach	Arthur L. Trask, West Palm Beach	4th Mon.	70	404
<b>Palm Beach</b> *Hendry	James T. Cook, Marianna	Richard H. Schulz, Marianna	1st Thurs.	1	30
<b>Panhandle</b>	Gail M. Osterhout, Inverness	William Lazenby, Tarpon Springs	2nd Thurs.	—	51
<b>Pasco-Hernando-Citrus</b> *Sumter	James C. Fleming, St. Petersburg	Donald G. Nikolaus, St. Petersburg	1st Mon.	134	483
<b>Pinellas</b>	Howard M. DuBose, Lakeland	Clyde E. Gibson, Lakeland	2nd Wed.	20	230
<b>Polk</b>	Charles E. Barribeau, Palatka	William Green, Palatka	2nd Tues.	3	12
<b>Putnam</b>	James J. DeVito, St. Augustine	Anthony J. Mussallem, St. Augustine	3rd Tues.	—	24
<b>St. Johns</b> *Flagler	Ronald E. Allison, Stuart	Bernard D. Ross, Ft. Pierce	3rd Thurs.	—	40
<b>St. Lucie-Okeechobee</b>	Elbert W. Sutton, Milton	Claude J. Barnes, Milton	2nd Tues.	—	14
<b>Santa Rosa</b>	John N. Carlson, Sarasota	Charles E. Koch, Sarasota	2nd Tues.	27	183
<b>Sarasota</b>	Kenneth M. Wing, Sanford	Nicholas Pastis, Sanford	2nd Tues.	1	38
<b>Seminole</b>	Leo F. Klenk, Jasper	Hugo F. Sotolongo, Live Oak	1st Sat.	—	7
<b>Suwannee-Hamilton-Lafayette</b>	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	—	9
<b>Taylor</b> *Dixie	Thomas W. Ayres, Daytona Beach	James A. Carratt, Daytona Beach	2nd Tues.	7	155
<b>Volusia</b>	Lloyd L. McCormack, DeFuniak Spgs.	Thomas G. Spence, DeFuniak Spgs.	3rd Tues.	—	8
<b>Walton</b>			Total	1,248	7,113



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**WANTED**—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

**FAMILY PRACTITIONER** to join 15 man multispecialty group in Central Florida. Excellent fringe benefits together with pleasant working facilities in an area famous for excellent recreational opportunities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

**FAMILY PRACTITIONER** to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

**SEEKING FAMILY PRACTITIONER:** Pleasant rural community, well established, growing community in central Florida. Located in center of horse country, good fishing on Orange Lake. Near state teaching hospital. Clinic building available. Contact Town Council, P.O. Box 138, McIntosh, Florida 32664. Phone (904) 591-1214.

**CENTRAL FLORIDA AREA:** Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

**GENERAL PRACTITIONER NEEDS ASSOCIATE** immediately. Florida license necessary. Salary, then partnership. Location Lake Okeechobee. All sports. 60 miles from both coasts. 90 miles from Miami. Call (813) 983-8531.

**GENERALISTS/FAMILY PRACTICE.** A dynamic medical group practice emphasizing quality personal medical care and social responsibility may want you. Present group of 10 expanding. New offices, top quality management insures high standards and high income with excellent growth potential. Florida license required. Contact: John Buckingham, M.D., MPH, Tampa Medical Center, 1950 West Buffalo, Tampa, Florida 33607.

**THRIVING THREE-MAN FAMILY PRACTICE** in suburban Miami area looking for a fourth man. No OB, no surgery. Excellent salary with full corporate benefits, moving towards full partnership. Large hospital practice. Write to Miami Lakes Medical Center, 14045 N. W. 67th Ave., Miami Lakes, Florida 33014, or telephone 821-6600.

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**INTERNIST, UROLOGIST, GP's:** Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

**INTERNIST,** board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

**INTERNIST WANTED:** To join busy board certified internist in growing suburban area central east coast of Florida. Excellent hospital and residential facilities. Write C-593, P.O. Box 2411, Jacksonville, Florida 32203.

**PATHOLOGIST POSITION AVAILABLE** soon AP-CP and Florida boards required. Small group North Florida. Great climate, beautiful area, stimulating professional atmosphere. Reasonable financial arrangements. Write C-594, P.O. Box 2411, Jacksonville, Florida 32203.

**PEDIATRICIAN FOR ASSOCIATION:** With pediatrician in busy central Florida area. Salary first year, percentage and partnership to follow. Florida license required. Write C-584, P.O. Box 2411, Jacksonville, Florida 32203.

**INTERNIST WANTED:** Preferably cardiologist, to join board certified cardiologist-internist in Dade County area. Military obligation must be completed. Write C-600, P.O. Box 2411, Jacksonville, Florida 32203.

**OTOLARYNGOLOGIST WANTED:** Association leading to rapid partnership. Liberal initial arrangements. Florida Space Coast area. Board qualified or certified, under age 40. All aspects of modern ENT. Phone (305) 724-2718.

**OB-GYN AND PEDIATRICIAN URGENTLY NEEDED** in expanding south central Florida town. All sports. 60 miles from coasts. GP. carrying load alone forming clinic. Florida license necessary. Call (813) 983-8531.



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**DUNEDIN,** Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

**PHYSICIANS NEEDED:** Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

**DEVELOPING MULTISPECIALTY GROUP** oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Urologist, Internist, Cardiologist, Pediatrician, General Surgeon, Orthopaedist, and OB-GYN. Contact: H. D. Williams, M.D., President, Marlowe, Williams, Abbey & Sells, MDs, PA. Richey Medical Center, P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

**PHYSICIAN WANTED:** Miami area, no hospital work or house calls. Group practice. Suitable for man who wishes to work 30-40 hours per week and devote time to family and recreational activities. Will consider part time or semi-retired. Florida license required. Write C-599, P.O. Box 2411, Jacksonville, Florida 32203.

**PHYSICIANS WANTED:** St. Augustine (Flagler Hospital) desires the following Florida licensed physicians to meet the growing community needs: General Practitioners, E.R. Physicians, Pediatrician, Otolaryngologist and Ophthalmologist. New professional building ready in August. Financial assistance available. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone (904) 829-5676.

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**UROLOGIST:** Board certified, 36 years old, university trained, F.A.C.S.-F.I.C.S. Five years in private practice, desires to move to a warmer climate. Write C-588, P.O. Box 2411, Jacksonville, Florida 32203.

**BOARD CERTIFIED UROLOGIST** with excellent surgical training. Not licensed in Florida. Would be valuable as assistant in operating room. (House staff status.) Prefer Gulf Coast. Would consider other location. Write C-601, P.O. Box 2411, Jacksonville, Florida 32203.

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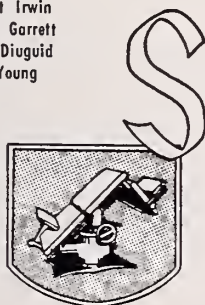
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# JFMA

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AUG 15 1973



VOL. 60, NO. 8

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC. AUGUST 1973





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Division of Hoffmann-La Roche Inc.  
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# Valium® (diazepam)

To help you manage excessive psychic tension



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AUGUST, 1973 • VOLUME 60 • NUMBER 8



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AUGUST COVER—On the cover is a sketch of a "Snowy Egret" done on the medium of scratch-board. The technique is to scratch out the black ink surface on a chalk covered board. The only place where these drawings are widely published is in The New Yorker magazine where for years the well known artist, Micossi, has had thumbnail sketches. Our drawing is a detail made from photographs and sketches taken in a swamp north of Clearwater, Florida years ago by Robert C. Lonergan, M.D. who is now retired and living in San Diego, California and is one of our most enthusiastic readers.

should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could allow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
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Must vasodilators  
and therapy for  
other diseases  
come into  
conflict?



not if the vasodilator is

**VASODILAN<sup>®</sup>**  
(ISOXSUPRINE HCl)

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no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: Geriatrics 25:134-148 (May) 1970.



## President's Page



### AMA — New York

The cab sped ahead with intermittent prolonged delays from LaGuardia through the hot, muggy, smog-filled city to the 1973 AMA Convention at the Americana Hotel. There was no gentle southerly wind caressing palms; no birds singing cheerfully in the summer skies. Instead, the gray buildings, drab streets, unsmiling humanity, and light drizzle cried out simultaneously. We were in New York.

I realized that for the next few days, I would not be having fun with the children, playing golf, or practicing medicine. Instead, I would be representing my state at a "stereotyped, non-productive, ineffective" AMA convention.

Five days of observation and education quickly ensued. So now it was mine to be involved nationally; to see men like Drs. Holland, Dobbins, Zellner, Day, Broadway and Connor, all at work as delegates. To meet with twenty or thirty Floridians at 7 a.m. daily for conferences, decisions and general support of the grass roots FMA philosophy.

The dedication, the self-sacrifice of time, the sincerity and devotion, all proved that these men represented Florida well. Their actions disclaimed all the past vilification aimed at the AMA. Remaining alert throughout meetings and working on the job at hand were routinely accomplished by not only ours; but, the delegates from the other states as well. Men working in concert for true humanitarian causes, without remuneration or economic gain, signaled an organization with professional giants as leaders.

The work was voluntary, and more democratic than the activities of the United States Government in Washington. This was brought into focus when a Kentucky physician, a mere dues-paying AMA member, debated a psychiatric issue on the floor of a reference committee meeting. His position was later sustained by the House of Delegates, thus revealing a true grass roots movement in action.

Our membership reads the daily newspapers and derives a very significant concept of what our organization stands for, instead of the official AMA pronouncements which tend at times to contain too much verbiage. Despite the ignorant carping of the critics, decade after decade, the AMA organization forges ahead. Space really limits my dissertation, but I commend you to read about the council on medical education, the pre-Flexner AMA day of diploma mills, the end of the Krebiozen type promotions, and others—for the AMA serves your profession well.

Certainly, whether they realize it or not, the public profits immensely because of the role played by the AMA in upholding standards of competence. Doctor Roth, our new president, stated: "It is a fact that physicians who have elected not to participate in organized medicine have profited immensely from its activities even though they have not paid their way."

We are truly fortunate that so many doctors are attracted to the voluntary membership in an organized society like the AMA. When one realizes that no doctor has to belong to a medical society and no medical society can evoke, suspend or abridge the state-granted right to practice, how can the voluntary associations exert the influence they do?

Too often we are asked "Why should I join the AMA?"; "What does the AMA do for me?"

Doctors, the answer is simple. You should have been with me in New York and listened, watched and learned.

A stylized, cursive signature in black ink.

**Because you  
practice  
medicine in the  
Sunshine State...**

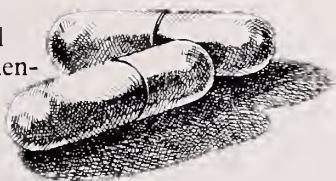




**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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### University of Florida Graduates Sixty One

Dr. William Jape Taylor, left, professor and chief of cardiology with the University of Florida College of Medicine, congratulates three award-winning new physicians following commencement ceremonies June 10 for a class of 61, including five women, who received Doctor of Medicine degrees at the Reitz Union. The graduating Class of 1973 heard, at their invitation, an address by Dr. Taylor, who said: "The Oath of Hippocrates you will shortly embrace is emblematic of a blending of science with humanism and high ethical standards. I believe that education, however achieved, should serve to mold, to develop and to protect the integrity of the individual, which in concert becomes the moral foundation of society at large."

"You will have to be flexible in your responses to the inevitable changes in our system of health care delivery and finance. Patients, too, deserve new empathies, and a better partnership in understanding and planning of their health care needs. I hope that your years in our midst have aided in your educational maturity so that you can face the challenges for medicine, as well as society at large, with an ability to examine problems openly, objectively and then decisively to make creative decisions."

"I will cherish your Hippocratic Award and watch your future careers with affection and pride."

Award recipients are: Dr. Bayard Miller of Gainesville, 2nd from left, recipient of the Upjohn Achievement Award for highest academic achievement; Dr. Warren Ross of Tampa, one of three recipients of the Faculty Award for Research; and Dr. Edgar Lee (Gary) Thomas of Jacksonville, right, winner of the John B. Gorrie Award, given to the graduate chosen by the faculty as "the best all-around student showing promise of becoming a practitioner of the highest type." Dr. Thomas also received the Faculty Award for Research and the Watson Clinic Award for Research, given by the Watson Clinic of Lakeland.

### AMA Pamphlets Available

Three pamphlets on community health and health care of the poor are available from the American Medical Association.

The publications are "Statement on Free Clinics," "Statement on Health Outreach," and "Committee on Health Care of the Poor: Progress Report." All were adopted by the AMA House of Delegates during the Clinical Convention in Cincinnati in 1972.

Copies are available free of charge upon request to: Department of Community Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

## ACP Inducts 11 State M.D.'s

Eleven Florida physicians were among 315 doctors throughout the United States and Canada to be admitted as Fellows of the American College of Physicians this spring.

The new ACP Fellows from Florida are: Raul L. Echenique, M.D., Coral Gables; Jan S. Hirschfield, M.D., Clearwater; James R. Green, Jr., M.D., Gainesville; Martin E. Liebling, M.D., Barry J. Matterson, M.D., Jay H. Sanders, M.D., Wayne E. Tobin, M.D., and Adel A. Yunis, M.D., all of Miami; Daniel D. Nixon, M.D., and Simon Rozen, M.D., both of Miami Beach; and Alan L. Haslup, M.D., St. Petersburg.

## Family Practice Review Course

The Division of Continuing Education of the Medical University of South Carolina will sponsor its Fourth Annual Family Practice Review Course in Charleston, S.C., September 24-29.

The American Academy of Family Physicians has approved the course for 40 credit hours. Tuition is \$140.

Information may be obtained by contacting Vince Moseley, M.D., Director, Division of Continuing Education, Medical University of South Carolina, 80, Barre St., Charleston, S.C. 29401.

## Speaking Seminars Slated by AMA

The American Medical Association Speakers Training Program will have three seminars next fall, all at the American Management Association's training facilities near Chicago's O'Hare Airport.

The sessions will include theory and drills on message preparation, delivery, body language, fielding of questions, individual coaching, evaluation and instant TV playback.

Dates for the 1973 seminars are September 1-2, October 27-28, and November 17-18. Each seminar will be limited to 40 participants and a fee of \$50 will be charged.

Information may be obtained by contacting Mr. Mortimer T. Enright, Director, AMA Speakers and Leadership Programs, 535 North Dearborn Street, Chicago, Illinois 60610.




Gov. Reubin O'D. Askew is shown signing into law legislation exempting the records and proceedings of hospital and medical review committees from the process of discovery. The legislation, enacted by the 1973 Florida Legislature, had the full backing of the Florida Medical Association. It is believed the new law will increase the effectiveness of review committees. Watching the Governor sign are (l. to r.): Mr. Donald S. Fraser Jr., Director of the FMA Department of Public Affairs; Julian H. Groff, M.D., a member of the FMA Committee on State Legislation; State Rep. Walter W. Sackett, M.D. (Dem-Dade); Sanford A. Mullen, M.D. Chairman of the FMA Council on Legislation and Public Agencies, and State Rep. Richard S. Hodes, M.D. (Dem-Hillsborough).



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- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

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PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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1. Gordon, E. E. and Haas, A.,  
Indust. Med. & Surg. 28:217, May, 1959.

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# Implications of Federal Funding on Academic Health Centers

E. M. PAPPER, M.D.

During the past decade society's expectations of academic medicine have completely altered the traditional roles of our nation's medical schools. The public asks that its medical schools to be a part of the community and to serve it. The schools are expected to be providers of referral types of medical service, to introduce model health care delivery systems, to produce more physicians, to offer unusual educational opportunities for minorities and the disadvantaged, to accelerate training programs of physicians without loss of quality, to provide continuing education and simultaneously maintain the high standards of education and biomedical research that have characterized the last two decades. The legislative processes initiated in the late fifties and early sixties may have enabled academic health centers to become all things to all people; unfortunately, the events of the past several months (i.e., the Administration's FY 74 budget) make it unrealistic to assume that this nation's medical schools will be able to accommodate the demands of society and continue to maintain their basic excellence in medical education and biomedical research.

It is not possible to cover here all of the implications of the Administration's recommendation on programs of the nation's schools of medicine; however, it is important to consider a few aspects of the President's recommendations that could have far reaching effects on the continued growth of Florida's medical schools.

If the proposed budget suggested by the Administration is approved by the Congress the federal funds available in fiscal 1974 for support of teaching, research, and service would drop more than 15 percent from the current level, and 26 percent from the level anticipated prior to the release of the January 29th budget message. The Association of American Medical Colleges has made a national survey to determine the effects of this budget reduction on our medical schools.

Dr. John Cooper, President of the AAMC, reported that such an appropriation could cause schools to terminate "one out of every 12 faculty members unless other sources of salary can be obtained." One third of the schools reported that they may have to reduce the size of future entering classes. Curriculum innovation may come to and abrupt halt and many schools will have to seriously reconsider the anticipated shortening of the process of medical education.

Federal support for new biomedical research may be severely cut. The loss will not be felt this year but will eventually result in the loss of faculty as well as stop the tremendous advances that have been made in medical research during the past several decades. Not only will the dollar amounts be reduced but the types of grants supported will be considerably different. The shift in emphasis will be from the individual grant to the larger grants with teams of researchers attacking targeted areas such as cancer, heart, lung and blood diseases. It is expected that this concept of NIH funding will be broadened and that most grants will be made to Centers rather than individuals investigators. The latter concept is probably a good one and could provide more efficient biomedical research *if the fiscal support for all programs were available.*

Of special concern is the fact that the fiscal 1974 budget proposes to phase out the research training and fellowship programs supported through the NIH. This would result in a "44 percent reduction in trainees and a comparable amount of support of faculty." Representative Paul Rogers of Florida has submitted legislation in Congress to provide specific statutory authority to continue the training grant and fellowship programs operated by the NIH. Although it is probable that such a Bill will pass the House and Senate, it is uncertain whether or not the Congress will have the necessary support to override a Presidential veto.

Finally, it is important to consider the im-

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

plications of Public Law 92-603, commonly known as HR-1. Last year, Congress passed HR-1 which is an amendment to the Social Security Act of 1972. Section 227 of the Bill concerns payment to physicians in a teaching setting for services rendered to Medicare patients. This section follows the guidelines of previous intermediary letters issued by the Bureau of Health Insurances and incorporates into the law a very strict and severe limitation as to when physicians in a teaching setting may be reimbursed on a fee-for-service basis for services rendered to Medicare patients. The law now provides that the teaching physician will be reimbursed on a cost basis providing: (A) the patient is a bonafide private patient or (B) the hospital has charged all patients and collected from a majority on a fee-for-service basis. It is obvious that the intent of Public Law 92-603 is to reduce the payment from Medicare trust funds to physicians in a teaching setting. It is anticipated that this law will create serious problems for a large number of faculty participating in professional income plans and will result in loss of revenue to medical schools.

It is apparent from these *few* examples that there is a paradox. Society wants the best possible medical care but the burden of support is a political football. The University of Miami School of Medicine does not intend to sit on the side lines and observe. It has been active nationally both through the Association of American Medical Colleges and testimony before congressional committees. In the area of biomedical research we have responded with four Center grants and have already been successful in obtaining funds for three comprehensive Centers. In order to meet the expectations of the state and community which we serve we will have to obtain greater support locally. I am optimistic that Florida will continue on the path toward medical excellence. Within the last two decades the state government has established three fine medical schools and one dental school. Local government has been most responsive to the health needs of their citizens. They have cooperated fully in the development of the new medical centers. Without this support in the future biomedical progress is certain to level off.

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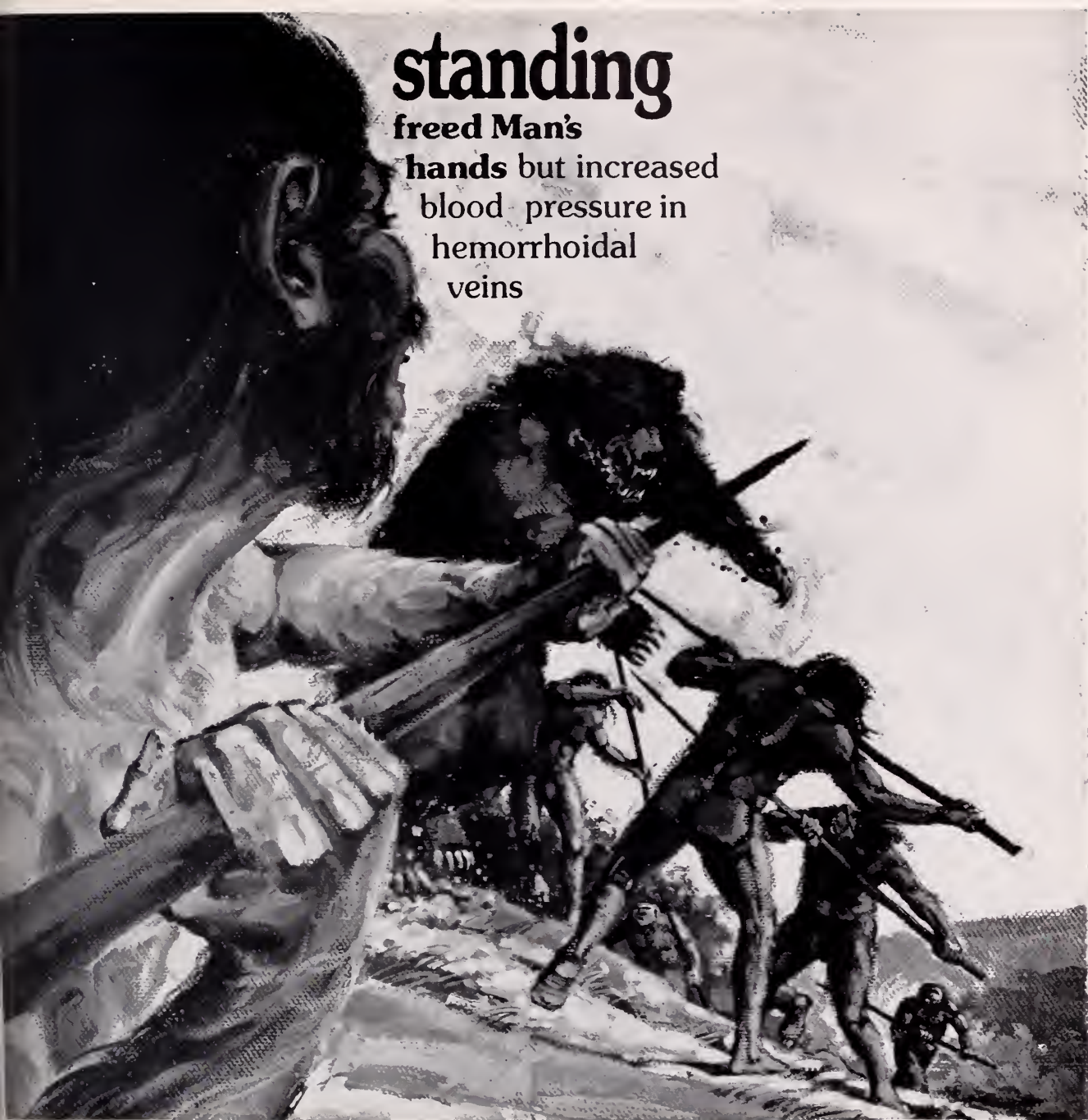
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## Summary - 1972 / 1973 School Year

The following data summarizes the reported status of children enrolled in kindergarten and first grade in keeping with Florida's Compulsory Immunization Law. The Guidelines for compliance with the law specify that all children entering Florida public or private kindergartens or first grades are to be immunized against diphtheria, whooping cough, tetanus, polio, measles, and rubella before being enrolled.

### Children Enrolled in Kindergarten or 1st Grade with:

Area	Schools	Students	Certificate of Immunization PD-137*		Medical Exemption PD-139**		Religious Exemption PD-138***		No Documentation	
			#	%	#	%	#	%	#	%
Florida	1890	195644	159377	81.5	22355	11.4	237	0.1	13675	7.0
Alachua	29	3445	2931	85.1	512	14.9	2	0.1	0	0.0
Baker	2	399	381	95.5	18	4.5	0	0.0	0	0.0
Bay	22	2533	1646	65.8	140	4.9	0	0.0	747	29.5
Bradford	5	447	400	89.5	46	10.3	1	0.2	0	0.0
Brevard	55	7410	4808	64.9	30	0.4	9	0.1	2563	34.6
Broward	164	16493	13858	84.0	2338	14.2	18	0.1	279	1.7
Calhoun	3	290	265	91.5	2	0.7	1	0.4	22	7.4
Charlotte	9	573	479	82.0	101	17.5	3	0.5	0	0.0
Citrus	5	727	392	53.9	50	6.7	3	0.6	282	38.8
Clay	14	1492	1026	68.8	465	31.2	1	0.1	0	0.0
Collier	11	1645	1227	74.6	260	15.8	6	0.4	152	9.2
Columbia	9	1060	776	73.2	27	2.5	0	0.0	257	24.3
Dade	263	33196	26334	79.3	6535	19.7	57	0.2	270	0.8
DeSoto	2	372	313	84.1	50	13.4	0	0.0	9	2.4
Dixie	2	260	235	90.4	25	9.6	0	0.0	0	0.0
Duval	240	19219	16133	83.9	603	3.1	10	0.1	2473	12.9
Escambia	68	7414	6618	89.3	68	0.9	2	0.02	726	9.8
Flagler	1	157	157	100.0	0	0.0	0	0.0	0	0.0
Franklin	3	240	216	90.0	24	10.0	0	0.0	0	0.0
Gadsden	30	1430	954	66.6	1	0.1	0	0.0	475	33.3
Gilchrist	2	157	141	89.8	16	10.2	0	0.0	0	0.0
Glades	1	142	104	73.0	0	0.0	0	0.0	38	27.0
Gulf	3	365	365	100.0	0	0.0	0	0.0	0	0.0
Hamilton	3	328	288	87.8	14	4.3	0	0.0	26	7.9
Hardee	3	478	410	85.8	68	14.2	0	0.0	0	0.0
Hendry	3	204	195	95.7	0	0.0	0	0.0	9	4.3
Hernando	3	638	398	62.5	27	4.2	2	0.3	211	33.0
Highlands	10	768	641	85.8	103	13.4	0	0.0	24	3.1
Hillsborough	129	12033	10491	87.2	612	5.1	16	0.1	914	7.6
Holmes	5	436	292	66.9	73	16.7	0	0.0	71	16.4
Indian River	12	922	919	99.7	0	0.0	3	0.3	0	0.0
Jackson	9	1109	1064	96.0	3	0.3	1	0.1	41	3.7
Jefferson	2	384	301	78.5	83	21.5	0	0.0	0	0.0
Lafayette	1	39	30	76.9	9	23.1	0	0.0	0	0.0
Lake	20	2043	1427	69.8	391	19.1	5	0.2	220	11.1
Lee	57	3264	2509	76.9	569	17.4	2	0.1	184	5.6
Leon	27	3091	2746	88.9	144	4.7	7	0.1	194	6.2
Levy	6	315	268	85.1	8	2.6	0	0.0	39	12.3
Liberty	2	142	121	85.2	21	14.8	0	0.0	0	0.0
Madison	5	504	431	85.5	59	11.7	0	0.0	14	2.8
Manatee	18	2247	2014	89.6	230	10.2	3	0.2	0	0.0
Marion	24	2761	2138	77.4	6	0.2	3	0.1	614	22.2
Martin	9	861	659	76.5	199	23.1	3	0.3	0	0.0
Monroe	13	1324	825	62.3	9	0.7	0	0.0	490	37.0
Nassau	4	708	560	79.1	147	20.8	1	0.1	0	0.0
Okaloosa	28	3303	2198	66.5	1105	33.5	0	0.0	0	0.0
Okeechobee	2	221	176	79.6	41	18.6	4	1.8	0	0.0
Orange	101	10595	7688	72.0	2001	20.0	13	0.1	893	8.0

Osceola	7	770	751	97.8	4	0.5	1	0.1	14	1.7
Palm Beach	77	7811	5910	75.7	1695	21.7	17	0.2	189	2.4
Pasco	17	2269	1752	77.2	501	22.2	4	0.1	12	0.5
Pinellas	93	9956	9639	96.8	314	3.2	3	0.03	0	0.0
Polk	91	8099	7504	92.7	589	7.3	6	0.1	0	0.0
Putnam	10	1272	1238	97.3	0	0.0	1	0.1	33	2.6
St. Johns	14	1040	840	80.8	122	11.7	2	0.1	76	7.3
St. Lucie	12	1186	739	62.3	444	37.5	3	0.2	0	0.0
Santa Rosa	14	1387	1149	82.8	4	0.3	2	0.2	232	16.7
Sarasota	14	2802	2768	98.8	23	0.8	11	0.4	0	0.0
Seminole	34	3624	3386	93.4	200	5.5	1	0.1	37	1.0
Sumter	6	343	320	93.4	23	6.7	0	0.0	0	0.0
Suwannee	3	594	431	72.6	0	0.0	0	0.0	163	27.4
Taylor	2	435	346	79.5	88	20.2	1	0.2	0	0.0
Union	1	172	153	89.0	0	0.0	0	0.0	19	11.0
Volusia	42	4474	2805	63.1	1022	22.8	9	0.2	638	14.3
Wakulla	3	292	197	67.4	70	24.0	0	0.0	25	8.6
Walton	7	505	482	95.4	23	4.6	0	0.0	0	0.0
Washington	4	429	429	100.0	0	0.0	0	0.0	0	0.0

\* PD-137—Child immunized with 4+ doses DPT, 3+ doses OPV, 1 dose Measles, 1 dose Rubella.

\*\* PD-139—Child immunized with all possible vaccines at this time.

\*\*\* PD-138—Child's parents requested exemption on religious grounds.

## Salmonella

*Editor's Note: This series summarizes proceedings of the conference arranged by the Florida Medical Association's Committee on Public Health and the Environment and co-sponsored by the Association and the Division of Health, Florida Department of Health and Rehabilitative Services.*

A gastroenteric infection manifests itself by fever, diarrhea and vomiting 12 to 48 hours after exposure to a common source or contact with an infected person, and usually is self-limited. The infected person may have no symptoms or very mild symptoms. A minority seek medical attention. Those with uncomplicated disease usually require no specific treatment. Antibiotics do not significantly modify the clinical course and do prolong the duration of excretion of salmonella. A particular drug may give an initial response but with time the organism becomes less and less susceptible to it. There is no well-known, accepted cure.

Three groups of infected persons have special implications: nurses and attendants, food hand-

lers, and persons anticipating hospitalization or pregnant women approaching term.

Those who become infected should be advised that certain precautions against spread are necessary for several weeks, principally careful handwashing. A patient scheduled for elective surgery should postpone the procedure. When hospitalization is necessary, enteric stool precautions should be instituted. In an epidemic situation routine culturing of all contacts rarely is necessary unless these persons engage in patient care and food preparation. There is no specific solution to the problem of spread among institutional populations, particularly hospital nurseries.

The clinician takes the first step toward control of infection when he arranges a fecal culture on patients with diarrheal disease, particularly those with fever. The second step is reporting the case with positive findings. This is most inadequately done. Even when the patient is hospitalized, there is a certain reluctance to report.

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## Florida's College of Veterinary Medicine and Human Health

CHARLES E. CORNELIUS, D.V.M., PH.D.

Plans are underway to add a sixth college, College of Veterinary Medicine (CVM), at the J. Hillis Miller Health Center of the University of Florida. The instructional and biomedical research programs will be integrated where appropriate with current programs at the Health Center. The building plans include the addition of a basic science teaching and research wing at the Health Center and construction of an animal teaching hospital on a 140 acre site west of the Veteran's Administration Hospital. The new CVM is planned much along the same lines as a modern college of medicine. It will utilize the existing basic Medical Science Departments at the Health Center and add a Department of Clinical Sciences containing academic divisions of medicine; surgery; epidemiology and public health; laboratory animal, wildlife and aquatic medicine; radiology; clinical pathology; cardiopulmonary function and anesthesiology; obstetrics and gynecology; and special organ systems such as gastroenterology, ophthalmology, dermatology and dentistry. Hospital services will include sections for food animals, horses, small animals, exotic species, supporting services, and clinical specialties.

Specific objectives of the CVM will be:

To educate veterinarians who will be trained for specific needs of Florida. Elective educational tracks will include: comparative medicine, food animal medicine, epidemiology and public health, laboratory animal medicine, aquatic medicine, environmental medicine, equine medicine, urban medicine, and general veterinary practice. Interdisciplinary instructional programs related to human and animal health will be assigned a high priority.

To provide a biomedical investigational resource of animal disease models with human counterparts. This referral center will include both metabolic and infectious diseases.

To perform research on the devastating subtropical animal diseases that must be controlled in order to provide wholesome food for our nation and the developing countries.

To provide a Veterinary Medical Center necessary for the training of interns, residents and graduate students, and for continuing education of practitioners.

To provide an active referral and extension program designed for the veterinary medical profession, state and federal agricultural and public health agencies, and consumers of food and health services.

Major efforts will be made to orient the student to operate as a member of the health science team. Programs concerned with the urban environmental crisis and specific problems in the agricultural community will be stressed. With over 200 animal diseases transmissible to man, graduates will be trained in preventive medicine and epidemiology.

Veterinary medicine is still an emerging profession and must provide its own research on animal

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diseases and their interaction with the environment. No other medical group can provide this vital information. Through a sensitivity to research and diagnostic problems, extension programs will automatically disseminate key observations to the populace.

### The Unity of Medicine

The concept of comparative medicine is historically an ancient one. The great German pathologist, Rudolph Virchow, once stated, "Between animal and human medicine there is no dividing line—nor should there be. The object is different, but the experience obtained constitutes the basis of all medicine." It is quite fortunate that the fruits of comparative medicine are once again recognized by biologists as important contributions to the health sciences. That human and veterinary medicine developed as one is documented as early as 1900 B.C. in the medical literature of ancient Egypt, which included monographs on human and animal diseases. This early interdependence was evidenced also in the writings of Aristotle and Hippocrates. Ancient Greek scholars taught both branches of medicine and described the similarities of medical problems in many species. In the United States, Benjamin Rush, an illustrious name in medical education, stated in 1808 that veterinary medicine should be included as part of the curriculum of medical doctors. Veterinary medicine was closely linked in early days to the discipline of medicine at the University of Pennsylvania. In fact, the majority of faculty of the veterinary school founded in 1884 held M.D. degrees. William Osler also helped to forge close ties between medicine and veterinary medicine at the University of Pennsylvania. Osler's concept of "one medicine" convinced many that the study of medicine involved certain phenomena basic to diseases of all species.

Although the practice of the two professions has become separated in modern times, the research observations of the physician and veterinarian have continued to add to the common body of medical knowledge. Contributions to human medicine by veterinarians and to veterinary medicine by physicians have abundantly demonstrated a universality of medicine. Over 200 bacterial, rickettsial, viral, fungal, protozoan, helminth and nematode infections of animals are now known to be transmissible to man, and physicians and veterinarians in the late 19th century were particularly concerned with these diseases. D. E. Salmon, a veterinarian, and Theobald Smith, a

physician, first established that killed microorganisms could be used as vaccines. The first demonstration that a specific infectious agent produced a particular disease was provided by Robert Koch, a physician, using anthrax organisms and cattle as patients. The first demonstration of the role of an arthropod in the transmission of disease was provided by Theobald Smith and a group of veterinarians. Early steps in virology can be traced to the study of foot and mouth disease in cattle. The many discoveries of Karl F. Meyer, a veterinarian, in the fields of botulism, encephalomyelitis and ornithosis still stand as unique contributions to the health professions.

A new awareness now exists in the health science community concerning the unique contributions attributable to research in comparative medicine. Unfortunately, the many diseases that occur spontaneously in animals with similar counterparts in man either have been only superficially studied or still remain to be discovered. Conferences and recent reviews have stressed the advantages of discovering appropriate animal models in which to study the multiple causes of many human afflictions. The vast wealth of this neglected medical resource can be used to advantage only if new, coordinated interprofessional efforts are initiated between human and veterinary medical centers in collaboration with the many zoologic parks and biologic field stations.

Examples of recent contributions on animal disease models are:

1. Studies on atherosclerosis in pigeons and swine as related to human coronary heart disease.
2. Dissecting aneurysms in turkeys as an animal model for studying the causes of human aneurysms.
3. Studies on spontaneous hereditary diabetes mellitus in the Chinese hamster as compared to man.
4. Cyclic neutropenia of collie dogs, a hereditary blood defect.
5. La For's disease in dogs, a hereditary condition of the central nervous system.
6. Plant poisoning as a cause of cyclopia.
7. Pathogenesis of leukemias of birds as related to human leukemias.
8. Studies on dogs with lupus erythematosus as related to human immunologic diseases.
9. Comparative studies on granulomatous colitis of the dog and ulcerative colitis in man.
10. The use of mutant sheep with inherited jaundice to study the Dubin-Johnson syndrome in man and the hepatic transport of bile pigments.
11. Discovery and study of the Chediak-Higashi syndrome in mink and cattle as compared to man.
12. Aleutian Mink Disease, a virus causing hypergammaglobulinemia and nephritis. This has helped open new knowledge of the pathogenesis of glomerulo-nephritis in man.
13. The comparative study of viral lymphomas in cats and cattle as related to human leukemia.



14. The discovery of a variety of animals with blood coagulation defects such as Hemophilia in dogs and swine, Christmas disease in dogs, and Factor VII deficiency in dogs.

15. Ehlers-Danlos syndrome, a hereditary connective tissue defect found in dogs and mink and similar to the human disease.

16. Pathogenesis of canine distemper encephalitis as a model for subacute sclerosing panencephalitis in man.

17. Scrapie of sheep as a prototype of slow virus encephalopathies.

18. Marek's disease of chickens as a model for Burkett lymphoma and other herpesvirus neoplasms.

19. Comparative studies on kidney and bladder stone formation in sheep, cattle and man.

20. The study of hepatoma in trout.

21. The comparative study of inherited porphyrias in man, cattle and cats.

22. The observation of horses with spontaneous chronic pulmonary emphysema as related to the disease in man.

23. The discovery and study of a variety of inherited and nutritional muscular dystrophies in chickens, sheep and horses.

24. The study of a variety of inherited eye diseases in animals such as cataracts and retinal dysplasia with progressive atrophy.

25. Comparative studies on pregnancy toxemia in sheep and in humans.

### Animal Diseases and Man's Well-Being

**ANIMAL PROTEIN WASTAGE.**—There is no doubt that animal protein deficiency remains the number one public health problem in the world, resulting in marasmus and kwashiorkor. This food wastage is no doubt the most important consequence of animals' diseases to man. The interaction between feeding mankind and animal diseases is complex; but with our present status of medical knowledge, these overwhelming food losses are in large measure preventable. It is frightening to think that 60% of the people of the underdeveloped areas, comprising two thirds of the world's population, suffer from this problem. The veterinary profession is internationally accountable since five major diseases account for the majority of the 30-40% animal protein wastage. Unfortunately, protein deficiency particularly affects young children and pregnant and lactating mothers.

**AQUATIC MEDICINE.**—The world population continues to increase at a faster rate than its ability to produce sufficient food. The accelerated harvesting of aquatic animals can provide important animal protein to prevent human suffering and the resultant politically unstable world. Veterinarians are needed to control the diseases of these aquatic animals and provide the quality-control techniques to insure their wholesomeness as food. The many problems of fish toxins, fish diseases, and contaminations in our environment must be further investigated.

**THE ENVIRONMENT.**—More veterinarians must

be trained to participate in many vital programs regarding our polluted environment. Many presently work in public health offices concerned with smog control; water and sanitation programs; microbiological testing; diagnostic laboratories; pollution from animal wastes in water run-offs; toxicology testing using chemical and fish-testing systems; research programs concerned with the interaction of wildlife and pollution; to mention only a few.

**THE ZOOSES.**—Many of the diseases of animals remain the most serious diseases of man in the developing countries. Something over 200 zoonoses and a variety of food poisonings are either directly or indirectly communicable from lower animals to man. Although less than 50 significant diseases are known in which man is the sole host, some of these may be found in the future to also be shared with other mammals. Although the majority of these have been partly controlled in such areas as the United States, Australia, and Western Europe, much of the remainder of the world is in an agonizing state. It is obvious that these diseases must be reduced in man through controlling them in lower animals. The profession of veterinary medicine must soon dedicate itself more greatly to this international insult to mankind.

The protection of our personal health against the diseases of companion and farm animals transmissible to man is a top priority item in our own state. The city and rural veterinarian plays a key role in preventive medicine. Adequate numbers of veterinarians trained at the University of Florida's new college will insure the provision of wholesome meat and prevent the spread of local animal diseases, as well as the introduction of devastating exotic foreign diseases into our livestock population.

The role of the small animal practitioner in larger cities such as Miami, Jacksonville and Tampa—who routinely prevents companion animals from infecting our families with rabies, histoplasmosis, tuberculosis, hydatid cyst disease, leptospirosis, many serious fungal diseases, intestinal disorders from salmonella, and a variety of other diseases—must be fully appreciated. The role of the veterinarian in farm practice as a doctor of preventive medicine has long been appreciated and recognized in rural America.

### Summary

Human and veterinary medicine must cooperate more fully and strengthen each other's teach-



ing and research programs in many ways. A number of steps should be taken:

(1) Human and veterinary medical schools should be built and developed in close proximity to permit maximum cooperation of both faculties. Teaching and research in graduate programs in the basic sciences and postdoctoral specialties in both schools should be integrated as closely as possible. (2) Resources facilities for experimental animals should be enlarged in existing health centers to allow for the handling of a variety of animal species and to facilitate the selection of proper biomedical models for research projects. (3) Greater faculty and student interchange between human and veterinary medical schools will stimulate an appreciation of comparative medicine and help insure recognition of the similarities between human and animal diseases. (4) The number of research symposia on the comparative aspects of many disease processes should be in-

creased. (5) Administrative conferences between the two professions should be increased to insure long-term planning for a productive integration of research and teaching activities. (6) Collaborative research projects between investigators at human and veterinary medical schools should be encouraged.

Some of veterinary medicine's greatest contributions to mankind in the future will be what basic information flows into the health sciences. There must be closer ties than currently exist between the two professions to allow for these contributions. It is imperative that shorter lines of communication be established between all health science faculties. Florida's new College of Veterinary Medicine has a unique opportunity at the University of Florida to contribute in a variety of ways to the health of man.

► Dr. Cornelius, J. Hillis Miller Health Center, University of Florida, Gainesville 32601.

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## To Approve or Not Approve PSRO(Sic)

To approve or not approve PSRO, that is the question.  
Whether 'tis nobler in the mind to suffer the slings and arrows of outraged physicians,  
Or to take arms against the bureaucrats,  
And by opposing—achieve what end? To despair; to surrender  
No more; and by surrendering to say we end the heartache and the thousand tangled regulations  
MD's are heir to, 'tis a consumation devoutly to be wished.  
To surrender; perchance to cooperate; aye, there's the rub  
For in that delusion the fate that may befall us when we have capitulated  
Must give us pause. There's the respect  
That makes a virtue of docile compliance;  
For who would beat the whips and scorns of petty officials,  
The secretary's insults, the President's power,  
The pangs of third party interference, and the insolence of office?  
But we are charged with implementation of the law, And we cannot our quietus make  
Until we serve and support our Peer Review Committee.

By E. D. Morton, M.D., Editor, Utah Family Physician, Winter 1973.

# Thoracic Aorta to Femoral Arteries Bypass Grafting For High Aortoiliac Occlusive Disease

DANIEL B. NUNN, M.D. AND MUHAMMAD A. KAMAL, M.D.

**Abstract:** This paper presents a description of a new surgical procedure for the treatment of patients with high aortoiliac occlusive disease (arteriosclerotic involvement of the entire infra-renal aorta and iliac arteries). The procedure entails the use of a dacron bifurcation bypass graft extending from the distal descending thoracic aorta to the common femoral arteries. The paper also offers a case report illustrating the use of the bypass procedure and a comment concerning the advantages of the procedure.

Since the pathologic changes of arteriosclerotic aortoiliac occlusive disease are usually confined to the terminal abdominal aorta and common iliac arteries, most patients undergoing aortoiliac surgery can be treated by endarterectomy or dacron grafting while the infra-renal aorta and iliac arteries are temporarily occluded. The presence of significant arteriosclerosis in the proximal infra-renal aorta, however, contraindicates temporary aortic occlusion at this level. Patients with high aortoiliac occlusive disease who are suitable candidates for surgery are ordinarily treated either by procedures requiring temporary occlusion of the suprarenal aorta and the renal arteries<sup>1</sup> or by axillary-femoral artery bypass grafting.<sup>2</sup> Dissection of the suprarenal aorta and the renal arteries is technically difficult, and even temporary occlusion of these vessels may be followed by renal failure and hypertension. Axillary-femoral artery bypass grafting is a simpler and safer procedure, but the axillary-femoral artery graft, in its subcutaneous position, is continually vulnerable to external compression with resultant thrombosis. Consequently, axillary-femoral artery bypass grafting is recommended for use only in poor-risk patients with advanced ischemia, rest pain or signs of impending gangrene in the lower extremities.

In an effort to improve the surgical treatment of good-risk patients with high aortoiliac occlusive disease, we have developed and successfully utilized a new procedure which involves the insertion of a dacron bifurcation graft extending from the distal descending thoracic aorta to the common

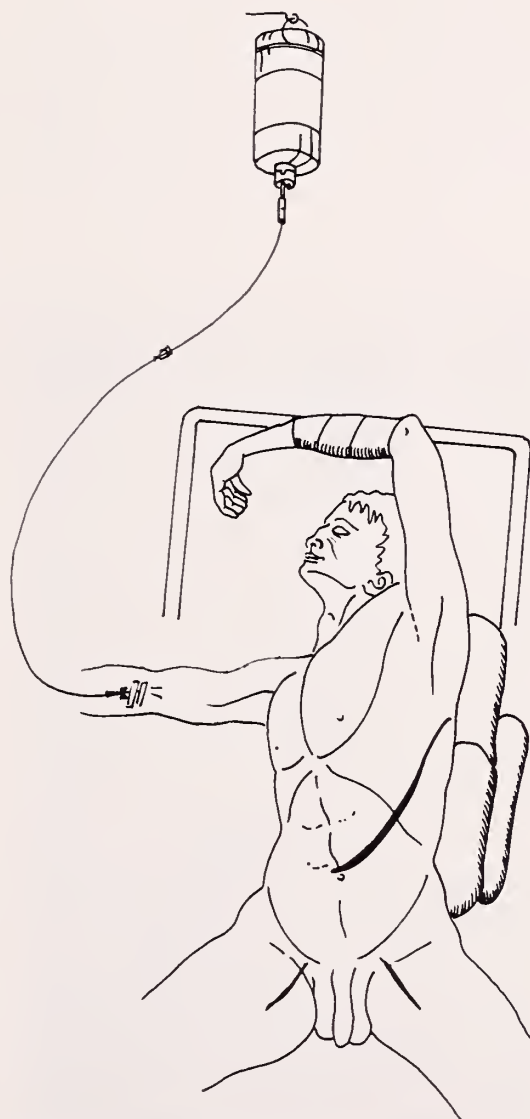


Fig. 1.—Operative position of the patient and site of the surgical incisions.

From the Department of Surgery, St. Vincent's Medical Center, Jacksonville, Florida.

femoral arteries.<sup>3</sup> This paper presents a description of the operative technique, a case report illustrating the use of the bypass procedure, and a comment concerning the advantages of this new procedure.

### Operative Technique

The operative procedure is performed with the patient in a right semilateral decubitus position. Initially, the femoral arteries are exposed through vertical groin incisions to evaluate their status. If the outflow tract appears adequate, a left thoracoabdominal incision is made beginning in the 7th or 8th intercostal space and extending obliquely across the upper abdomen (Fig. 1). The diaphragm is divided to the aorta and the spleen, stomach, and proximal left colon are reflected toward the patient's right side. A partial occlusion arterial clamp is applied to the distal descending thoracic aorta, and a vertical arteriotomy is made in the excluded portion. The aortic end of a dacron bifurcation graft, measuring 16 x 8 x 8 mm. which is previously clotted with blood aspirated from the aorta or femoral artery, is sutured end-to-side to the aorta with continuous 4-0 cardiovascular sutures. After completion of the anastomosis, the clamp on the aorta is removed and placed across the graft immediately distal to the anastomosis. The graft is placed in a retroperitoneal position anterior to the left kidney, and the limbs of the graft tunneled to the groin wounds. Each limb is then sutured end-to-side to the appropriate common femoral artery using 5-0 cardiovascular sutures (Fig. 2). If necessary, a femoral endarterectomy is performed prior to completion of the latter anastomoses. The diaphragm is closed around the aortic portion of the graft and the spleen, stomach, and left colon are returned to their original positions. The operative incisions are closed in a standard manner, and the left pleural cavity is drained with a thoracotomy tube.

### Case Report

A 50-year-old Caucasian female was admitted to St. Vincent's Medical Center on September 18, 1972, because of disabling claudication and rest pain involving the left lower extremity. Symptoms began in February, 1972, following surgery for vertebral artery insufficiency caused by arteriosclerotic narrowing of the proximal left subclavian artery; a left thoracotomy had been performed with insertion of a dacron graft end-to-side to the proximal descending thoracic aorta and end-to-end to the left subclavian artery immediately proximal to the origin of the vertebral artery. The patient related that she was unable to walk more than ten to 15 feet before experiencing severe cramping pain in the left hip and thigh. In addition, she was taking 50 mg. Demerol every three hours for rest pain occurring in the left lower extremity when

recumbent. Prior to quitting in 1967, the patient smoked less than one pack of cigarettes per day.

In 1967 an endarterectomy of the infrarenal aorta and common iliac arteries and bilateral lumbar sympathectomy had been performed because of disabling claudication involving both lower extremities. Six months later, claudication in the right lower extremity had recurred as a result of arteriosclerotic narrowing of the right external iliac artery. On September 3, 1969, a saphenous vein graft had been inserted end-to-side to the right common iliac artery and end-to-end to the distal right common femoral artery.

Physical examination revealed a slender well-developed female. A systolic bruit was audible over the left supraclavicular space, and the intensity of the left radial pulse was diminished. Supine blood pressure was recorded as 160/90 in the right arm and 136/100 mm. Hg. in the left arm. The lungs were clear to percussion and auscultation. There was no clinical cardiomegaly or cardiac murmur, and a normal sinus rhythm was present at 76 beats per minute. A systolic bruit was detected over the epigastrium and right lower quadrant of the abdomen. Femoral, popliteal, and dorsalis pedis pulses were present in the right lower extremity and were of fair quality; a systolic bruit was audible over the right femoral artery. There were no pulses in the left lower extremity although the general appearance of the extremity was satisfactory.

A routine blood count, urinalysis, SMA-12, PA and lateral chest films, and EKG were within normal limits. A lipid package revealed a Type IV lipoprotein electrophoretic pattern; triglycerides were 199 mg.% and cholesterol 217 mg.%. A translumbar aortogram (Fig. 3)

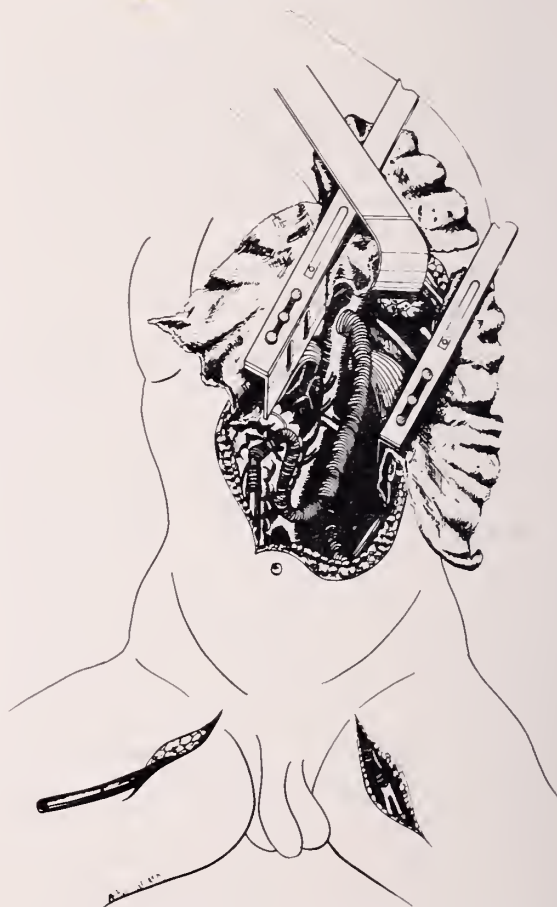


Fig. 2.—Illustration of the operative procedure showing the graft sutured to the descending thoracic aorta and the left common femoral artery. A tunneler has been inserted to facilitate passage of the right limb of the graft to the groin wound.





Fig. 3.—Translumbal aortogram.

showed normal renal arteries and narrowing of the entire infrarenal aorta and proximal right common iliac artery with complete occlusion of the left common iliac artery. The vein graft extending from the right common iliac artery to the right common femoral artery was patent, but there appeared to be aneurysmal dilatation of the distal portion of the graft (Fig. 4). Distal run-off seemed satisfactory bilaterally in delayed films of the femoral arteries.

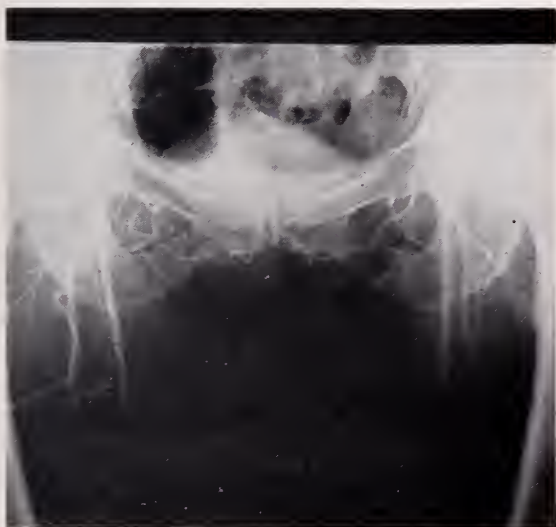


Fig. 4.—Arteriogram showing aneurysmal dilatation of vein graft (right side).

Surgery was performed on September 26, 1972, utilizing a left thoracoabdominal incision and bilateral groin incisions. The aortic end of a dacron bifurcation graft was sutured to the side of the distal descending thoracic aorta, and each limb of the graft tunneled retroperitoneally to the appropriate groin wound. Following an endarterectomy on the left common femoral artery, the left limb of the graft was sutured to the side of this vessel. The localized vein graft dilatation in the left groin was found to have occurred at the site of intraluminal valves. The dilatation was corrected by excising a vertical ellipse of the dilated portion of the vein; the right limb of the dacron graft was then sutured to the side of the vein graft at the point of excision (Fig. 5). Good pedal pulses were present after the operation, and the post-operative course was uncomplicated. Two months following surgery, the patient related that she was able to climb three flights of stairs without having to stop and rest.

### Comment

Thoracic aorta to femoral arteries bypass grafting offers several advantages for the treatment of good-risk patients with high aortoiliac occlusive disease. Attachment of a bypass graft to the descending thoracic aorta, which is seldom significantly arteriosclerotic, is technically easier and safer than endarterectomy of the proximal infrarenal aorta. The bypass procedure also

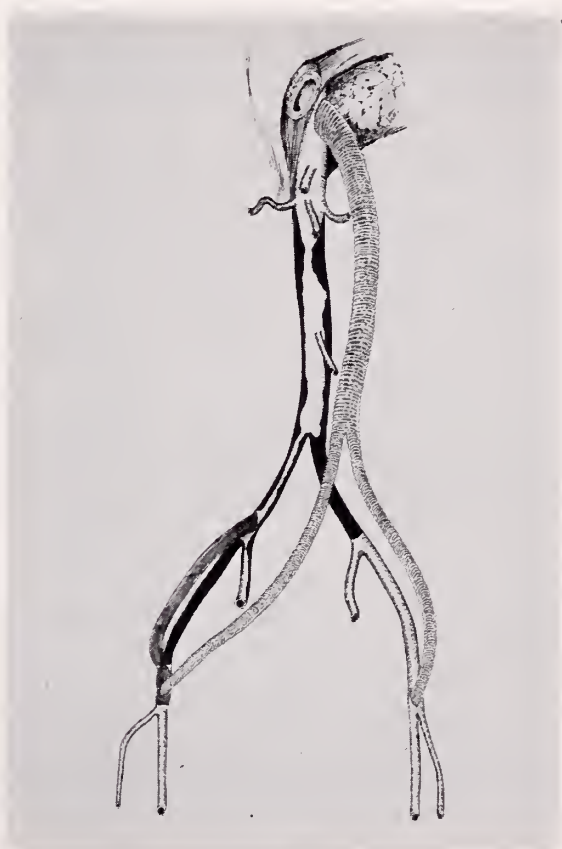


Fig. 5.—Diagram of the surgical procedure.

avoids potential postoperative renal complications which may follow temporary occlusion of the suprarenal aorta and the renal arteries. Bypass grafting from the thoracic aorta to the femoral arteries is particularly useful in the treatment of patients with high aortoiliac occlusive disease who have undergone previous aortic surgery. The use of the bypass procedure in such patients avoids hazardous dissection near the scarred aorta and its branches.

### Acknowledgment

We wish to express our appreciation to Dr. Andre Renard for the illustrations contained in the paper and to Miss June Howell for typing the paper.

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## Medical Musings

F. NORMAN VICKERS, M.D.

In last month's column, we promised more quotations from Harry Schwartz, Ph.D., economist, author, and member of New York Times Editorial Board. Dr. Schwartz appeared on a panel on PSRO's in April at the national meeting of the American Society of Internal Medicine. Dr. Schwartz expressed his doubts about the ability of the PSRO to improve the quality of delivery of medical care while reducing costs; however, he urged physicians to participate in the PSRO, which has consumers on the panel. This way, if PSRO doesn't work, physicians have some other group with which to share the blame. He also pointed out that having the consumer on PSRO boards would allow them to function as ombudsmen for more care and hence the net effect would be more expensive. He pointed out that Congress didn't know what it was doing when it passed

Medicare and Medicaid and in spite of the information from organized medicine, Congress didn't know the price tag. He pointed out that one of the problems of government subsidized medical care was that there were no effective built-in regulators of costs. "Any sensible economic system has built in regulators since, I believe, there is a streak of larceny in all humanity."

In the discussion which followed, Dr. Schwartz believed that there should be a legal prohibition against first dollar insurance. He would also raise deductibles for Medicare. "If you and your doctor know it is going to cost you something, you will be more careful than if you know it will come out of the government's pocket."

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# Future Goals in Sports Medicine

PAUL F. WALLACE, M.D.

**Abstract:** Future goals in sports medicine include legislation in some areas leading to protection against possible injury among participants and enforcement of existing ordinances. The cure for the acute and chronic injuries is prevention as well as treatment. Conditioning commensurate with the sport is extremely important, also the regular checking of equipment. In the younger ages, boys should be separated by physical maturity rather than age. Care for the injured athlete must be readily available, relatively inexpensive and carried out by interested physicians. Of vital concern is designation of one hospital in each town for treatment of heat disorders.

In determining the capacity for injury, sports may be divided into low or no risk, medium and high risk. The more advanced, famous and lucrative the sport the more it is legislated for protection of participants. Generally the more lucrative sports present more risk of injuries and the less lucrative more an attitude of make-do concerning policing as well as equipment.

No driver or crew member would appear on the Daytona Speedway without wearing flameproof clothing; yet elsewhere races are held almost every week and flameproof clothing is never worn. Going on the field with the Dolphins without ankles strapped carries a \$100 fine; yet frequently uniforms are not worn in sandlot football.

Injuries can be classified as acute such as sprains, ruptures, fractures, hematomas, heat disturbances, lacerations and abrasions; and chronic—blisters, ingrown nails, infections, corns and callouses and tendinitis. Injuries arise from legitimate and illegal contact in football; weather which provokes lightning, rain and cold, and playing fields.

Lacerations, abrasions and infections arise from artificial turf, infections from grass and burns from wood surfaces. Equipment gives a variety of problems caused by improper fit, protruding rivets, fasteners, shoes of wrong size or

out of repair and broken cleats. Fatigue, as in an overextended condition, and balance loss while pivoting, changing direction or speed, can lead to acute and chronic conditions. Finally, injuries resulting solely from accidental causes probably can have little more done by way of prevention.

In general the cure for injury is prevention as well as treatment. Conditioning which is extremely important should strengthen muscles commensurate with the sport. In the younger groups, boys should be separated by physical maturity rather than age. Equipment should be regularly checked as well as hygiene and nails, particularly in the younger athletes, for an ingrown nail can sideline the most promising member of the team.

Doctors, trainers and coaches should quickly recognize an injury and recall the player at the first sign, particularly in high schools and colleges. They should be familiar with the symptoms of heat prostration and know the essentials of maintaining fluid balances.

## Future Goals

At automobile races points of protection have been legislated but the ordinances are not enforced, particularly at the smaller tracks.

Golf, archery and volleyball provoke few injuries and little needs to be done to make these sports safer.

Tennis may cause epiphyseal irritations in young players. When an injury occurs, time off from practice must be allowed for full recovery. Blisters and ingrown toenails are problems. Tennis elbow occasionally results from too much practice or a heavy racket.

Track presents injuries associated with running, jumping and throwing. Proper shoes and foot hygiene become extremely important, also an awareness of heat difficulties.

Water skiing problems arising from no mirror, two people in the boat, not wearing a flotation jacket, and skiing close to fixed objects have been legislated but need enforcement.

Horseback riding should require a helmet. One is not available now but this measure should

Dr. Wallace is Chairman of the Committee on Sports, Florida Orthopedic Society.



be legislated. An approved motorcycle helmet, covered and with visor attached, may be used.

Gymnastics need legislation. No one should work without someone to guide and protect them from coming down the wrong way.

Ice skaters probably require little additional protection but helmets should be worn in hockey.

Swimming presents few problems other than overdoing by the young person in the butterfly kick and possibly adductor epiphyseal irritation.

Diving gives few problems as long as it is into a designated area, unless extremely high diving is being carried out. Most high divers have severe degenerative arthritis in the neck.

All softball players should wear gloves.

In baseball, a better helmet should be designed for batting. The present ones are an improvement but provide limited protection. In the Little Leagues the number of innings allowed pitchers at any one time are pretty well set. Very little additional protection appears possible for occasional injury to fingers and bones. Present day shoes appear adequate, particularly in the Little Leagues. As far as shoes are concerned, basketball presents big problems. Too, more space is needed behind the basket.

In soccer, lacrosse and Rugby, some type of protective headgear is indicated.

Wrestling seems to require little or no additional attention at this time but the young boxer should wear a protective helmet and all boxers should wear protective mouthpieces.

A first class playing field is an absolute must in football. Players should wear protective mouthpieces at all times. Special care must be taken in nail hygiene. No squatting knee exercises should be allowed, nor the duck walk or running up and down bleachers. Further development is necessary on shoes that allow the player to maneuver and still minimize knee problems. Ankles should be strapped for practice and each game, and the new type helmets employed rather than the outdated ones used by most teams. Signs of head injury should be well known and each player carefully observed for possible development. Practice should cease at the first sign of lightning. On artificial turf the high incidence of abrasions and lacerations dictates that all players wear long sleeves, elbow pads and stockings which fully cover the legs. Spectators should be protected by a net behind goal posts—not from the ball but from spectator fights for the ball.

## Plan for Care

Care for the injured athlete must be readily available, relatively inexpensive and carried out by interested physicians.

There are not enough orthopaedists to attend all local high school football games; therefore, players must be treated by other qualified physicians. Active recruitment is needed, and I would include osteopathic physicians. In certain areas interns and other house staff are available. They should be paid possibly \$20 for each game.

There is no question that trainers such as medical corp retirees must be trained, utilized and paid. The objective is to have someone other than coaches capable of recognizing possible serious injuries. Also the trainer would be responsible for seeing that patients obtain follow-up care when a doctor is not immediately available. Trainers should be certified locally and supported by a physician.

Most injuries resulting from an evening game can be treated the following day in the doctor's office rather than in the emergency room right after the game. The fact that the physician is readily available and interested encourages the players to go to the office. This reduces cost. Possibly no charge should be made for the patient found to be all right who was sent in by the trainer or doctor at the scene. Perhaps insurance costs are increasing due to routine care by physicians with interest and proficiency in special fields. Even with a serious injury, the cost of treating an athlete is less than a patient with a stroke.

It is necessary that the doctor know the coach and establish good rapport with him. Control of convalescence and return to play rests entirely with the doctor. This prevents the coach from urging the boy to play when he is not capable.

Of vital concern are the centers for the treatment of heat problems, maintained in a designated hospital and manned by specially trained personnel headed by the internist but under supervision of the orthopedist. The signs and symptoms of heat disorders should be taught those engaged in field treatment so early steps can be taken.

Centrally locating the area where the injured athletes receive treatment results in considerable motivation and competition on their part to get well. This is of untold importance.

► Dr. Wallace, 1501 Fifth Avenue North, St. Petersburg 33705.

# Bubble-Bath Cystitis and "Cosmetic" Vulvitis

## Neglected Hazards

H. J. ROBERTS, M.D.

**Abstract:** Serious urethritis and cystitis can be caused or aggravated by habitual bubble-bathing, especially when highly perfumed. The disorder tends to be more serious in diabetic women and young children. This potential source of irritation should be routinely sought out—and contraindicated—in patients presenting with renal tract and genital infections. Comparable advice also extends to such related irritants as perfumed soaps, douches, scented or dyed toilet tissue, and a variety of preparations used for "feminine hygiene." Widespread instruction, and possibly legislation, concerning these neglected hazards is needed to minimize the dangers of chronic urinary tract, genital and dermatologic complications stemming from their unbridled use.

The persistence of complaints indicative of irritation within the urethra and urinary bladder (the "sterile urethral syndrome") repeatedly taxes the diagnostic and therapeutic efforts of clinicians and urologists. Their importance is underscored by the frequency with which urgency or burning of urination are indications or forerunners of potentially serious renal-tract infection, especially in children and diabetic women. The purpose of this report is to reemphasize the oft-overlooked roles of bubble-bath preparations and a variety of other commonly used local "cosmetic" preparations that can irritate the urethra, vulva and perianal tissues.

### Bubble-Bath Cystitis

I have encountered ten patients—all adult females—in whom acute or recurrent urethral-bladder irritation was precipitated or aggravated by habitual bubble-bathing with preparations that can be readily purchased for this purpose. Seven

had overt or chemical diabetes mellitus. Four had undergone repeated urologic and gynecologic study because of the refractory nature of these symptoms. In one instance, they were erroneously attributed to a Wertheim operation performed a decade earlier. Others were regarded as having the psychogenic "irritable bladder syndrome" or its synonymous counterparts ("cystalgia," "vesical neuralgia"). Upon the cessation of bubble-bathing, generally with little or no other change in therapy, their urinary complaints promptly subsided. Moreover, the majority of these patients subsequently have remained free of lower urinary tract symptoms over prolonged periods of observation.

The relatively stereotyped clinical pattern encountered, and the favorable responses to stopping bubble baths, were described in an earlier communication.<sup>1</sup> Accordingly, only two representative cases will be presented.

### Case Reports

A 23-year-old obese school teacher was found to have a fasting blood glucose concentration of 217 mg.% when first seen in consultation. There was a bilateral family history of diabetes mellitus. Other pertinent features included recurrent edema, severe dysuria, and repeated renal tract infections. In spite of sulfonamides and antibiotics (oral and parenteral), her urinary complaints recurred, as did the associated bacteriuria. She had been seen in prior consultation both by a gynecologist and a urologist. Each prescribed additional local and systemic measures—but without lasting benefit. Intravenous urograms were normal. Her diabetes was satisfactorily controlled with diet and phenformin, the fasting blood glucose concentration progressively declining to 110 mg.%.

The patient's urinary tract symptoms persisted for two years in spite of conventional instructions relative to proper vaginal and bowel hygiene, the cessation of coffee and alcohol, avoidance of other potential irritants, and the foregoing management. It was then ascertained by *direct query* that she had been taking bubble baths several times a week. Within one month after their termination, urinalysis was normal. There has been infrequent dysuria over the ensuing four years observation.

A 69-year-old female presented with symptoms of postmenopausal osteoporosis, angina pectoris, and a severe peripheral neuropathy. Her fasting blood glucose concentration was 143 mg.%. On a program of diet, phenformin and supportive measures, both the fasting and postprandial blood glucose concentrations normalized. Concomitantly, there was dramatic improvement of her neuropathic discomfort.

This patient also had been troubled with recurrent renal tract infections for several years. Hospitalization

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was required two years previously for a bout of pyelonephritis, and on a subsequent occasion for another severe febrile attack. In spite of normalized blood glucose concentrations (fasting and postprandial), meticulous care concerning local hygiene, avoidance of alcohol, coffee and spices, and intermittent antibiotic therapy, her bacteriuria and pyuria persisted. On direct questioning, she indicated that she took prolonged and highly perfumed bubble baths several times weekly. Her urinary tract symptoms and bacteriuria disappeared shortly after avoiding these baths and have not recurred over three years of observation.

A number of individual clinical variations and "incubation periods" were encountered. The following instances are noteworthy.

An acute urethritis and cystitis developed within several days after the patient added a new soap-oil preparation to her bath.

In another patient, bubble bath had been initiated only two weeks prior to the onset of urethral symptoms.

A third patient had inadvertently put too much perfumed soap powder in her bath several days before presenting with a severe urethritis and cystitis.

#### Other Forms of "Cosmetic" Urethritis, Vulvitis and Dermatitis

A number of additional preparations are believed to have caused or aggravated the "sterile urethral syndrome," vulvitis, or a perianal dermatitis in more than a score of patients. They include (1) "feminine hygiene" sprays, (2) scented toilet tissue, (3) dyed toilet tissue, and (4) scented or chemically treated facial tissues. In each instance, cessation of the offending preparations, with or without other treatment (viz., local bland soaks, glucocorticoid cream, prednisolone, corticotropin gel)—depending on the severity of the inflammatory response—effected prompt improvement.

The combination of a dye and perfume in toilet tissue can be particularly irritating. For example, a diabetic female had considerable vaginal itching and inflammation following the use of a "softly scented" and colored toilet tissue. It is an unfortunate testimonial to the effectiveness of those marketing these products that the choice of such tissue frequently was predicated solely upon "matching my bathroom wallpaper."

#### Discussion

Bubble-bath cystitis is a term coined by the writer in 1967.<sup>1</sup> Prior references to such an entity by Marshall<sup>2</sup> and Simmons<sup>3</sup> were subsequently found. The *British Medical Journal*<sup>1</sup> has since editorialized on the subject. The fact that the foregoing observations, representing a doubling of

my earlier experience, were made solely within the context of a medical (i.e., nonurologic) adult practice indicates the magnitude of the problem.

The ability of bubble-bathing to cause severe cystitis and balanitis in children also is being increasingly appreciated. Marshall<sup>2</sup> indicated that irritative symptoms referable to the lower urinary tract in pediatric patients could be the direct result of bubble bath preparation. Bass<sup>5</sup> reported on 16 otherwise healthy children with "urethral or bladder irritations attributable to the regular use of bubble-bath preparations." Their complaints included urinary burning in the region of the meatus or at the penile tip, daily blood stains, lower abdominal pain, urinary frequency, or combinations thereof. These features promptly and permanently subsided in the majority after cessation of such exposure.

A number of physicians and laymen also have written me concerning their encounter of this problem in children. Several letters are germane.

A lay correspondent wrote concerning "a year-long bout with a urinary infection in 'my five-year old bubble-bath addicted daughter.'"

Two physician-parents expressed their initial anguish and frustration when they were personally confronted by this problem prior to recognizing its cause. After reading my initial report,<sup>1</sup> one physician indicated that her 5-year-old son developed severe itching, redness and swelling of the prepuce "after only two bubble baths with a popular children's bubble bath." Complete improvement occurred within several days following its omission.

The mother of another child with prolonged urinary tract difficulty caused by bubble-bathing expressed her indignation in this manner: "For a child to suffer needless examinations, x-rays and hospitalization while bewildered parents begin to think they are fighting a fatal disease is too high a price to pay because cosmetic firms are indifferent."

The substances used for bubble baths are mildly detergent preparations. They generally consist of sulfonated, petrochemical base products which are blended with neutral foaming agents. They have a pH of about 6.5, the recommended concentration in solution being 1%. Part of the popularity of these preparations resides in the absence of a residual scum deposit on the sides of the tub, as occurs following the use of soap. Moreover, it is now possible to produce soap bubbles of both phenomenally long life and large size by the



addition of water-soluble synthetic organic polymers.<sup>6</sup>

It can be presumed that the described urethritis and cystitis result from a direct mucosal irritation by ingredients in these products, and their irritating vapors. The usual absence of any listing of ingredients on the package or container has been justified by the continuing policy of considering bubble-bath preparations as "outside cosmetic" (*vide infra*). It is apparent from the foregoing clinical experiences that a definitive determination as to the safety of bubble-bath preparations and related products (*vide infra*) "intended for routine daily use" is overdue. Labels on bubble-bath preparations that contain phrases such as "kinder to the skin than fine toilet soap" should be substantiated by appropriate testing. The Chief of the Food and Drug Administration's Cosmetic Division, Alfred Weissler, has stated<sup>8</sup> that about 15 of the 250 complaints his department receives annually about cosmetics and toiletries pertain to bubble baths!

The urethritis and cystitis caused by bubble-bath irritants undoubtedly predispose these tissues to complications of a chronic nature. This is especially disconcerting in the case of diabetics and other patients having lowered resistance. One diabetic in the present series required prolonged antibacterial therapy before her pyuria and bacteriuria completely subsided. The possible role of bubbles in transferring large numbers of bacteria to the urethra, bladder and vaginal tissues is further suggested by the observation that air bubbles breaking at the air-water interface can remove bacteria present in the surface microlayer, and eject them in concentrations from 10 to 1,000 times that of the water in which the bubbles burst.<sup>7</sup>

The potential seriousness of chronic urinary tract and genital infections initiated in this manner during childhood should be cause for considerable concern. A recent feature<sup>9</sup> in *Today's Health* asserted: "Recently, two brands of bubble-bath had to be removed from the market and reformulated because they were linked to urinary tract irritations in young girls." This appropriate clause appears in Section 601 of the Federal Food, Drug and Cosmetic Act:

A cosmetic shall be deemed to be adulterated if it bears or contains a poisonous or deleterious substance which may render it injurious to users under the conditions of use prescribed in the labeling thereof, or, under such conditions of use as are customary or usual. . . . .

#### Reactions to Toilet Tissue

The local effects of scented or dyed toilet and

facial tissues pose yet another major related consideration. Keith, Reich and Bush<sup>10</sup> and Banov<sup>11</sup> reported on severe pruritus and contact dermatitis caused by scented toilet paper. The extent of this problem is indicated by the inability of several of my patients to find conventional 2-ply unscented and uncolored toilet tissue in their local supermarkets, and the identical labeling of both perfumed and unperfumed "luxury" toilet tissue manufactured by a leading company.

The need for more widespread counsel concerning proper anal hygiene also warrants attention. Banov<sup>11</sup> emphasized the following: (1) blotting rather than rubbing (which tends to create breaks in the epithelium); (2) the use of cotton—first soaked in warm water and then in cold water—applied in a patting manner for patients having large hemorrhoidal folds or tags; (3) resort to a baby bulb syringe after defecation for persons who have difficulty in cleaning themselves, or who tend to soil their underwear by seepage of mucus and feces, and (4) use of a bidet (a disposable type has been marketed in recent years). He appropriately asserted:

In this age of concern for consumers, the manufacturer should reduce the appeal of softness, of color, of floral design, and of scent of toilet paper in advertisements and try to educate the people on how to take better care of the anal region.

The possible long-term hazards of these products for children in terms of initiating or perpetuating renal tract infections, eczematoid reactions of the perineal skin, and vulvovaginal problems are again underscored. For example, one patient had urethritis and cystitis from a widely-sold brand of "softly scented" tissues. She also remarked that her 5-year old daughter was complaining of recurrent but unexplained vulval pruritus. Within days after shifting to unscented toilet tissue, the discomfort of both ceased and has not recurred during five months follow up.

#### Reactions to "Feminine Hygiene" Preparations

The cutaneous and mucosal irritation produced by aromatics, volatile irritants, divers chemicals and aerosols in local "feminine hygiene" applications is indicated by their ability to cause acute or recurrent urethritis, vulvitis and dermatitis. Simmons<sup>3</sup> described a high incidence of vulvovaginitis among women using detergent or perfumed soaps for bubble baths and douches. The cutaneous irritation of perfumes also can occur in men. This has been convincingly demonstrated by the severe dermatitis resulting from perfumed

after-shave preparations and deodorants with the "renaissance of men's toiletries." Only brief mention need be made of the severe nasal, sinus and bronchopulmonary reactions following hair sprays and underarm deodorant aerosols, even with sarcoid-like reactions having been reported August 1971 in *Postgraduate Medicine*.

There has been an enormous increase in the production and promotion of feminine spray deodorants in the United States since their introduction into the American market in 1966. An estimated 24,000,000 women in the United States use such sprays, more than 30 different brands having been made available by the end of 1971.<sup>12</sup> Most contain an antiseptic (such as hexachlorophene or methylbenzethonium chloride), an aerosol propellant (such as Freon), an emollient, and a perfume or odor-destroying compound, or both. Some of these formulas also include alcohol and talcum powder. Such a state of affairs has evolved from clever magazine and television advertising, wherein it is hinted that (1) many women emit offensive vaginal odors, and (2) these feminine hygiene deodorants could be the solution to their "problem." A local female newspaper columnist<sup>13</sup> commented:

Only Madison Avenue could devise such a diabolical advertising campaign as the one that has, by means of degrading women, created an artificial demand among women for a product of questionable value and probable hazard. . . . How can we be such docile dupes that we actually pay money for a product of such dubious quality that it poses a health hazard. . . .

Individual gynecologists and dermatologists have written letters to medical journals indicating their concern over encountering many local inflammatory or allergic reactions to these products.<sup>12, 14</sup> Although no specific figures have been published as to the incidence of such local reactions, the opinion has been expressed that it "must be around 10%."<sup>15</sup> They include vulvitis (in the absence of vaginitis), a "weeping" type of dermatitis, various types of hypersensitivity (including pruritus, burning and edema), and even chemical burns.<sup>12</sup> These adverse effects could be attributed to the following: (1) an allergic reaction (i.e., verified by patch testing), (2) the primary irritant effect of alcohol, hexachlorophene, and other substances on mucous membranes or skin, (3) the rapid cooling action of Freon on mucous membranes, and (4) injuries due to high pressure of the propellants, especially if incorrectly applied. When vigorously employed, these sprays can come in contact with the internal tis-

sues. It is generally recognized that the skin is not an altogether impermeable barrier. Various chemicals may be absorbed, especially through cuts or abrasions and adjacent mucous membranes.

The problem of "feminine hygiene" preparations recently has received attention in the wake of demonstrable brain damage in infants and burn patients, and in experimental animals, exposed to large amounts of hexachlorophene.<sup>12, 16</sup> Winthrop Laboratories reported that newborn monkeys washed daily for 90 days with a 3% hexachlorophene solution developed brain damage similar to that observed in rats.<sup>16</sup> The public has been exposed to some 400 different products containing hexachlorophene, ranging from soaps to cosmetics and vaginal deodorants.<sup>16</sup> Most gynecologists and dermatologists decry the need for such sprays, feeling that washing with a mild soap is sufficient.

It is assumed by the public that (1) all cosmetics have been thoroughly tested, and (2) their ingredients are known by the Food and Drug Administration. This is not the case, since cosmetic manufacturers are not required under the Federal Food, Drug, and Cosmetic Act to file formulas with the FDA, or to conduct safety tests before offering such products on the market. Moreover, Kiester<sup>9</sup> indicated that the cosmetics industry uses the lack of public complaints as justification for its argument that no restrictions on present policies are needed. According to the National Commission on Product Safety, however, more than 60,000 women annually suffer adverse effects from cosmetics of sufficient severity to cause them to seek medical attention.<sup>9</sup> It is believed that words such as "hygiene" and "deodorant," implying medical benefit, should not be permitted in the case of these products. One widely advertised "gyna-cosmetic" that "revolutionized douching" contains "four fabulous fragrances . . . raspberry, champagne, jasmine and orange blossom."

Yet another cause for concern is the contamination of most talcs with asbestos, which not only is a local irritant but potentially carcinogenic.<sup>18</sup> One feminine-hygiene deodorant was found to be composed almost entirely of talc on analysis by x-ray diffraction.<sup>18</sup> This problem becomes even more vexing in the case of cheap powder and other cosmetic products containing asbestos that are used by children.



## Comments on Treating and Preventing the "Sterile Urethral Syndrome"

Successful management of the "sterile urethral syndrome" necessitates the contraindication of bubble baths, other potential irritants, and the removal or correction of divers contributory factors. The latter include the irritation resulting from wearing tight or nonporous garments adjacent to the perineum (e.g., panty girdles, bathing suits), vigorous rubbing (rather than dabbing) with toilet tissue, habitual leg-crossing,<sup>17</sup> bacterial contamination of the urethra stemming from improper bowel, bladder or menstrual hygiene, faulty position during intercourse, the influence of atrophic menopausal changes, and the direct or indirect effects of various ingestants (e.g., spices, citrus juices, alcohol, coffee) and drugs (notably antibiotics, diuretics, and birth-control preparations). Other potential irritants deserving mention in this regard are contraceptive foams, douches, aerosol deodorants (especially when applied to sanitary pads during the menses), obsessive washing with soap and water, and allergic reactions to antioxidants incorporated within the rubber of contraceptive devices.<sup>4</sup>

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## The Message

I spoke to God and He answered saying,  
Go forth! I shall speak unto you  
Through the wind, and through the flowers,  
And all the earthly joys He hath  
Fulfilled the earth with . . .  
And I listened . . .

THE wind swayed the trees gently,  
And said unto me,  
"Reap your soul and let the wind  
Carry the pollen of love,  
To let it light softly upon the hearts  
Of these you have chosen to befriend . . ."

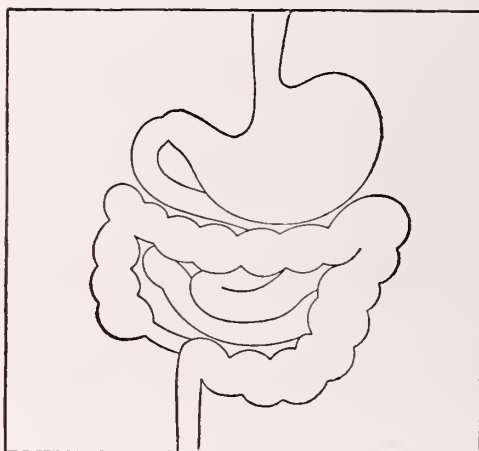
AND the flowers said,  
"Let this love flourish and from  
This you shall nourish . . ."

Then suddenly, as though a large chorus was singing,  
All the earthly joys spake unto me saying . . .  
"If ye shall love but once, and the love be true,  
Let not your heart be troubled  
For you are special, and those you love.  
I will send thee many friends  
Of which the fields of your soul  
Shall be replenished  
And I listened . . . And I am listening.

Debbie McBride  
Jacksonville



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## Special Article

# The Adolescent "Theft" Street Gang

N. HENRY PEVSNER, M.D. AND AUGUSTE MATHIEU, B.S.

**Abstract:** A modern type of adolescent street gang has been evolving into a more specialized type of "theft" gang in the metropolitan areas in the U.S. After outlining the continuing environmental factors, and more importantly the developing social and environmental frustrations acting upon the urban adolescent, the structure of his personality is stressed as the major contributing factor. The theme of the analysis appears to demonstrate the adolescent personality as an opportunist in its modern urban society.

A type of adolescent street gang has been evolving over the past decade in metropolitan America best called a "theft" gang. This association of adolescents provides their needs for (a) identification and the status of belonging to a specific group, (b) sharing the prestige of this group among other neighborhood groups, (c) having the security of a circle of friends, (d) and providing the receptive atmosphere for the members antisocial tendencies. This latter, the obtaining of money or material by stealing, is regarded with esteem and facilitated by the availability of accomplices (some experienced) and the means to convert loot into cash via a "fence" or gang contacts with persons in the neighborhood who will buy stolen merchandise. The underlying factors responsible for genesis of these gangs must be considered.

We might say the gang is formed because the members have failed to channel their inner desires and ambitions into socially acceptable endeavors. Historically the factors of crowded urban areas where one finds it harder to uphold individuality, the absent or negligent parent, the strong influence

of adolescent peer group, limited educational stimulation, and inferior economic position are still present. In addition some new elements in the environment are frustrating the individual. Improved mass media brings the wide diversity of opportunity and accomplishment to many persons who cannot hope to attain the kind of economic success they see pictured before them, and brings awareness of the lack of punishment or restriction for increasingly popular civil disobedience. Unchecked crime in low economic districts is a daily inescapability. Enforcement of punishment for crimes appears increasingly ineffective. And the increased acceptance of widespread drug abuse results from desire for an emotional release of tensions easily available in dismal socioeconomic areas, and the chance to make some money through drug dealing even in a small way.

Although these frustrations lead to antisocial outlets, the structure of the adolescent personality remains the most important factor in the genesis of antisocial adolescent groups. In gangs the adolescent seeks to attain identity—a member of a gang is "someone," the gang "can do what it wants," the gang can "outsmart" adults and police. Also the dynamics of adolescent motivation are constantly affected by the intensity of emotion he experiences. Feelings of the moment are invariably the paramount of the adolescents existence—although the strongest emotion at the time, something else may be "the best" or the "worst" he has ever felt after a short passage of time. This emotional structure influences all of his daily activities, his minor endeavors, his interactions with his peers, and his reaction to his experiences while "growing-up." By definition, adolescence is a time when mature physical and intellectual activity are possible, while childish



lack of foresight and irresponsibility are equally probable in daily living. The remnants of infantile feelings of omnipotence still allow the adolescent to attempt dangerous activities. Immaturity forestalls understanding the consequences of actions after the immediate time. The need for identity and individuality is very poignant. In other words, the child who in some ways can be an adult is frustrated because he cannot react nor comprehend as an adult.<sup>1</sup>

### Structure

The gang becomes the outlet for all these frustrations and gives adolescents the atmosphere where they can express themselves in one way open to them—rebellng against prevalent authority and setting their own standards of accomplishment. Needs for recognition and self-expression are the overt reasons for joining a gang—as evidenced by the ready admission of gang members that another gang might have been just as acceptable to join, and that in a gang “everyone knows who we are . . . buddies will stick up for me.” More subtly, the gang is outlet or protection for physical endowment or deficiency, feelings of self-importance, feelings of pride, strong concept of revenge, reaction to criticism and discipline, and reaction to the opposite sex. Under these circumstances many adolescents turn to the excitement and profit of stealing.<sup>1</sup>

Achieving this purpose generates an organizational structure within the gang. In the social area, several of the members will be physically and personally popular types, probably also with the girls, and tend to be leaders in any purely social activities. Physically superior members may be called upon to support the gang in fights with other gangs or back up individual members in their personal squabbles. This type group does not engage in any organized athletics, therefore negating any purely sports abilities of members. All members share in responsibility of maintaining their territory and position to the exclusion of other gangs at their specified “hangouts.” Some members will be the better versed “experts” in planning or executing thefts (and may be conspicuously absent from usual gang gathering places prior to a gang theft). But one member, by virtue of his keenness in finding good opportunities for thefts or burglaries will maintain the primary leadership of the gang. Now he will either be extremely astute in finding these opportunities or having been in jail or having learned some of the

tricks to breaking and entering and getting away uncaught (from other thieves), he will hold leadership through his brains. If he is a good leader and well liked he will be unchallenged. More often, however, a second member of the gang may have one of these attributes, greater experience in execution of thefts or natural ability to manipulate the gang members and he will act in conjunction with the leader as an effective vice-leader. He may be the one who determines what the real risks are for getting caught, which items can easily be turned into cash, what kind of approach to take to the theft and whether they will use their “muscle,” hit and run speed, confidence “con-artist” deception, or small size for slipping in somewhere. Early in the planning of any “job” will be the consideration of connections for disposing of the merchandise. This may be the other area of strength of the knowledge of the leader, or several other members may hold the position of “dealers” for the gang, and at this time assume their role of status. The dealers may either sell merchandise or have contacts with “fences” who will dispose of the goods. “Fences” may in fact have requested that the gang obtain certain items. Finally the leaders will decide how the gang will disperse after the theft and where the goods will be kept or transported to be safely available for sale.

### Status

Status within the gang is specifically related to the members ability and specialty in planning and executing a theft. But status related more to some of the emotional needs of the adolescent is more obvious when the gang structure is examined during less eventful periods when no theft is planned immediately. During these periods, hierarchy has the leader at the top, though he may share almost equal esteem with his vice-leader. Subsequent status is determined by physical endowment and personal popularity among the gang members and to some extent as reflected by their status among nongang members in the neighborhood or school. Other enhancements of status include previous police trouble, previous jail time served, success with the opposite sex, and length of time as a member of the gang.

The new member is chosen by his general acceptability in the neighborhood society. Possessing the minimum in acceptable physical and social characteristics, he must mirror the attitude of superiority the members feel their gang deserves.

Introduced by a member who is his friend or whom he has cultivated in order to get into the gang, the prospect will go through a very rigid trial period. He must be acceptable to most of the members and will be asked to prove himself by participating in some lone theft or activity to earn trust of the gang. Of course, the new prospect may have performed some such feat already, or have some special burglary ability or proven criminal audacity which actually brought the gang to recruit him without trial formalities (or even force him to join). In some gangs the formality may include a very rigid schedule of trials and probationary periods after which a formal vote is taken—a commentary on the stricter discipline the adolescent may often choose for himself than the discipline he rebels against. Full acceptance by the gang is finally interrelated with the new member's personal relations with other members and with his conformity to the gang's codes and rules—although he may strain his status in breaking norms of the gang either as far as his individual popularity lasts, or with this type gang, as much as his possible special services are valuable in thefts.

### Standards

Merchandise stolen by the gang becomes property of the gang, either owned by the gang or with a major ownership by one or several of the members if the result of a private unannounced sortie. Articles stolen, borrowed, or found in group activities are property of the group. Tools, weapons, stolen cars (if kept, though usually not for more than one theft "job") are freely available to the entire group from the individual gang member owner to the extent that he participates in the "job" or "rip off." This again is another important measure of status, as the possessor of the wanted item will be included in more thefts, just as the adolescent who seems to be able to find ready market for stolen goods is a desirable member of the gang. This status of "personal assets" remains in spite of the gangs requirements that all such implements are to be freely available to the gang when needed.

Assuming symbols such as gang name or emblem device have no intrinsic meaning or the same ritualistic importance as in other types of gangs. It is merely an expression of exclusiveness as a distinct group. Their reputation will surely be more for theft than toughness, although the gang

of course has provided the security and status of belonging to an established group, as well as the protection of numbers in a tough low economic neighborhood. In fact, by virtue of their financial success, these types of gangs have come to hold a unique position among the tough gangs, as they are esteemed for something that other gangs want to learn or at least a type of service they might want to use! Again perhaps this is a commentary on the polarizing of economic aspects as the primary values of American urban society.

Actions of the gang among members and with nonmembers are governed by strict norms. The most important in this gang are at first glance the initial standards for acceptance of physical, and specialized knowledge or skill. But, similar to all adolescent peer groups, there is much overlap with neighborhood adolescents outside their own gang. The member really loses more personally than the gang in any conflicts he loses. Therefore the members are not that far apart in dress and actions from most of the adolescents in the neighborhood. In fact the urban areas, where there are many types of gangs, usually generate "theft" gangs from some of the more resourceful, imaginative and pragmatic adolescents. These members therefore pay more attention to being less conspicuous, and avoiding conflicts which will interfere with their productive antisocial activity. Furthermore, the widespread recognition, if not acceptance also, of criminality as an effect of environment rather than of the individual has removed any ostracism from these "theft" gangs by their peers.

Understanding the genesis of this type of "theft" gang certainly requires analysis of environmental factors, however the environment is not necessarily the "shaper" of the adolescent as much as the adolescent personality is an opportunist in its environment—always managing to obtain the maximum of immature action within the constraints of the society in which it develops. To get away with as much as possible without getting caught is more characteristic of the adolescent dynamics than of our society, unless we might consider that society is becoming more adolescent.

► Dr. Pevsner, 6341 S.W. 34th Street, Miramar, Florida 33023.

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1. Pevsner, N. H.; Gomez, E., and Mathieu, A. P.: Working With Gangs, *J. Florida M. A.* 59:32-35 (Sept.) 1972.





## Are they too old to swing?

### EACH TESTAND-B TABLET CONTAINS:

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# What's on your patient's face...

may be more important than his chief complaint

Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

\*Data on file,  
Hoffmann-La Roche  
Inc., Nutley, N.J



# The lesions on his face are solar/actinic—so-called “senile” keratoses... and they may be premalignant.

## Solar, actinic or senile keratoses

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**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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## Editorials

### Fee Schedule Versus Relative Value Studies

Overcharging by physicians was a recurring complaint of patients and insurance carriers when I served as a member of our county medical society's Judicial Committee. In attempting to adjudicate these cases, application of the usual and customary fee scale was the only available criterion, but it begged the ultimate question. Determination of the usual and customary fee was difficult. It varied with the individual physician creating such a wide gap that no consensus could be reached. The median was not acceptable—the high-chargers accused us of overstepping our bounds.

The 1971 Florida Relative Value Studies were supposed to steer us into a standardized formula. It was useful but not the answer, designed to aid in determining fees. Medians of all charges are reflected. The individual charge may have no relation. Additionally there were sectional differences. Employment of a conversion factor to the unit values proved a slippery figure; it represented individual judgment.

Since the Relative Value Studies are not a fee schedule and were never intended to be, the obvious question is: Why not have a fee schedule? Before hurling the brickbats, pause for a sharp and critical appraisal.

It is apparent that sooner or later a national health insurance plan of some sort will be adopted. The Zeitgeist, the milieu of the times, demands it. Already we are marching to this beat of the drum. Government, large sections of industry, and insurance companies as well as the AMA and AHA have plans for nationalization of medical services.

Third parties have been interposed between us and our patients. Medicare has set itself up as arbiter as to how much we can charge. Insurance

companies are establishing their standards of a fair fee based upon their judgment of what is usual and customary. The recently enacted amendment to the Social Security Act, HR-1, PL 92-603, which mandates establishment of Professional Standards Review Organizations (PSRO), provides not only for medical audit but also for utilization review, thus bringing in such factors as fiscal data and maximum efficient utilization of services and resources. The challenge calls for quality medicine and for financial responsibility under an equitable system of financing. Eventually this will lead to development of a fee schedule for sturdy underpinnings and firm guidelines.

Thus, on every hand, we see the need of a realistic solution, perhaps a fee schedule with published straightforward figures. Unusual cases and complications will mean deviations. These should be kept to a minimum for firm actuarial data cannot be established if too many exceptions are made. Another argument against uniformity are sectional differences in fees. For instance, those in south Florida are higher than those in the northern part of the state due to increased costs and seasonal practice. In the long run, it is doubtful that a uniform system would result in loss of income. An advantage would be to prevent charges of rapacity and greed against these physicians. If the issue is irreconcilable and the high chargers are unwilling to abide by a uniform state-wide fee schedule, then it is better to have two fee schedules than none at all, even though this complicates the actuarial input.

The double-billing procedure necessary in some specialties complicates the present fee structure. The amount may be more than that of a single charge, even with adjustments for inflation.



This does not endear us to our patients. A firm fee schedule to apply to the total bill, regardless of fractionation, would correct this inequity and financial irresponsibility.

A bonus from employment of a uniform fee schedule would be the greater enticement of rural practice, thus correcting, at least partially, the maldistribution of physicians.

The present fee system invites insurance companies to trim fees. A dependable schedule would mean that actuarial controls could be established making payment for services predictable and certain for the full amount. Third party payers cannot cope with variable fees; arbitrarily imposed payments are the consequence.

To put a uniform program into operation, the initial action would be sanctioning by the majority of physicians. The schedule would have to be approved at the county medical society level; then surviving the in-fighting adopted at the state and national levels. Once adopted, published and disseminated, it would supplant Relative Value Studies and become the usual and customary standard—acceptable, definite and firm—to be used as a trustworthy guideline for adjudication of fees by third party payers and peer judicial councils. Annual recomputation based upon the state of the economy would keep it updated; thus assuring flexibility. The program would be completely voluntary with no penalties for non-compliance.

Difficult to implement, yes, but the obstacles are not insurmountable. There would be inter-

minable hassles and strident specialty voices. Consumer representation and government pressure to keep the figures low would add to the difficulties. The main hurdle would be physicians within our own groups, among them doctors who sincerely believe in the old order, obstinately refusing any compromises or revisions, forgetting that already we are in the throes of revolutionary changes. The conflicting pressures would be exerted at each annual revision, again sending the coronary arteries and anal sphincters into new spasms.

A fee schedule would be acclaimed as a step in the right direction by those aligned with us in the concerns of health care, and most of all by our patients. If we do not act the program will be set up by outsiders without physician input. Already we are conforming to schedules arbitrarily fixed for a large portion of our practice.

The final question is not whether a fee schedule will or will not be established. It is: Will we take the bull by the horns and set up a fair fee schedule, taking into account the economic realities of our practices, or by blind opposition and bickering let the opportunity pass and continue to be subject to fee adjustments not under our control?

These thoughts were prompted by an article entitled "The Case for a National Fee Schedule" by Gregory S. Slater, M.D., of New Britain, Conn., published in "Medical Economics," which I believed deserved further comment and elaboration.

WADE S. RIZK, M.D.

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## Justifiable and Commensurate

It has been suggested that to arrive at what should be a doctor's reasonable income, his contribution to society be compared with that of those in other occupations and his compensation be regulated by the amount of this contribution. But what constitutes a contribution? How can one measure one doctor's contribution against another? Can it be qualified? Can any qualifications be used as a practical basis on which to determine differences between doctors' incomes? In arriving at an answer, factors now influencing doctors' incomes are the seriousness of the disease treated, the difficulty of treatment, the number

of patients seen, the success or failure of the therapy, the number of doctors in each specialty and finally, the patient's degree of interest in obtaining a cure. Other factors, perhaps less fortuitous, are those of business ability and ambition rather than medical skills. So how can, or why should we haggle over a fee schedule that looks like a manifest for a supermarket? Making mockery of the stand against dual fee schedules, fees are paid according to geographic location and specialty with groups working at cross purposes to each other, so that we are unable to bargain effectively with third parties or the government.

Why not, instead, persuade the American public and the medical profession to come to some agreement as to what a doctor is really worth and find a method for determining this? The very nature of a profession as opposed to a trade makes absurd the concept that the event which takes place when a doctor meets a patient, is a recurring phenomenon, identical in visit after visit and with patient after patient. The present system focuses on individual morsels of practice turned out by the doctor, rather than on the value society receives from a doctor for his work.

First should be examined, the basic philosophy underlying both that controversial entity known as the Relative Value Scale and the whole system of fee-for-service. The original nature of a Relative Value philosophy of paying a fee for a visit as a certain unit of work has been modified to include paying for time and disease.

"In developing a Florida Relative Value scale a survey of fees for common procedures and services performed by FMA members was undertaken, hoping it to be statistically valid. The vast amount of data obtained was analyzed by computer and for many procedures, reliable median charges were determined. "The Relative Value Studies is a reflection of the practice of medicine in Florida. It is accordingly NOT A FEE SCHEDULE. It is a coded listing of physician services with unit values to indicate the relativity within each individual section of median charges by physicians for these services. . . ."

"The primary purpose of the RVS is to precisely describe and code the services provided by physicians. . . .The general acceptance of the RVS by insurance carriers and government agencies assures the physician who uses its coding and terminology that the services and procedures he performs are identifiable. With appropriate consideration to individual and local variations in practice, the RVS may also be used: (1) as a guide to physicians in establishing fees; (2) as a guide for insurance carriers and government agencies to determine their commitment, and (3) as a guide in evaluating individual claims." \*

This system, both unrealistic and unfair, approaches the question of how to compensate a doctor from the wrong end. If, by a quirk, the fee for a pediatrician's office visit is set a little low and the fee for reading a chest x-ray is set a little high, volume alone can deflate the pediatrician's income while inflating the radiologist's, all out of proportion to the contribution each is making by practicing his specialty or even out of proportion to the number of hours per week he works. A pediatrician goes into a low income specialty, not unaware of this but because he prefers having children as patients to making

a lot of money. Under the present system, each specialty, striving only to elevate its own fees, creates a distortion of fees that prevents achieving any unified bargaining effectiveness. Here, as in other aspects of organized medicine, unity is needed. Basic to the success of a comparative income system would be the assurance that this income is a realistic reflection of what the physician's service is worth to society in comparison with other doctors so each doctor would be required to justify the fee commensurate with the service provided and relative to the fees of those in other specialties. Such a change would be suggesting a way in which all physicians could be neatly arranged on a scale of fair, comparative incomes. This may be an impossible job but one that only our profession, with the help of others, could strive to accomplish. One yardstick for determining the variation of physician's income could be by using the number of years of resident training and the length of time spent in practice with percentage modifiers for unpleasant hours, during weekends, after midnight, or the hours producing inconvenience to a doctor's private life. An additional compensation for an unavoidable workload seems fair as well as considering varying geographic and specialty needs.

Now for the other horn of the dilemma; does fee-for-service preserve the sacrosanct doctor-patient relationship, or is its real importance that of keeping doctors happy? Has it outlived its usefulness or will it survive because it fills an essential need for patients as well as physicians?

In a free enterprise system the practicing physician is, in a sense, an entrepreneur and, as a businessman, has a right to charge a fee for a service as a social contract. Protecting the interest and freedom of the patient and the physician alike, the patient is free to choose his physician and to expect the fee to be commensurate with the services given. For standard services, the patient can learn in advance what the fee will be. If the two are not commensurate, he can change his physician.

The fatal illness of fee-for-service might well be iatrogenic from high fees charged by those who are killing the golden egg laying goose. The so-called emotional value of the fee can never compare with the real satisfaction of handling a tough medical problem and emerging with good results, yet there is more than a symbolic value to fee-for-service which isn't merely a rationale sought by doctors for collecting more money, say

\*FMA Relative Value Studies, 1971.



some. It is as vital to the patient as to the physician, for the patient needs to discharge his indebtedness in order to feel a sense of responsibility. The economic, as well as the emotional and intellectual sides of the doctor-patient relationship, are essential to preserve the patient's capacity for a full life. Robbing the patient of the emotional, economic satisfaction of giving, by a third party stepping in, exploits and institutionalizes the patient's dependency.

Another argument in favor of fee-for-service is that no matter whatever method of paying physicians, it will be made to conform to their wishes if the government has to bargain with them as suppliers of scarce services. However, as long as the government continues paying by a method doctors prefer, it can wring other concessions from them such as PSRO, complying with FDA regulations and the geographical distribution of medical manpower. Yet with the projected growth of governmental medicine and physicians continued preference for fee-for-service practice, increasing federal control of fees seems just around the corner.

HR-1, the giant package of social security amendments, has given legislators sanction to make uniform Medicare payment schedules in each geographical area, basing its reimbursements on the doctors' reasonable charges to be no higher than his customary charges or the prevailing charges for his area. The physician's only defense is refusing to accept assignments, which will require extra work for his office staff and a slightly reduced income. Yet this provides him the professional independence and integrity to set his fees at levels that he believes to be reasonable and equitable to all parties concerned. Accepting assignment, the average doctor is the economic slave of a Medicare data processing machine. Hoping for a somewhat higher income through certainty of payment is offset by the lessened degree of professional and personal freedom in setting fees and financial dealings with patients. In other words, the question is whether freedom

and independence of action for the physician is worth extra work and a slightly reduced income.

As the debate waxes hot over national health insurance, the fear grows of becoming government employees with the inefficiency and waste in bureaucratic systems. With this, fear of losing control of how medicine is practiced, a stand is taken for fee-for-service system, using the rationale of the necessity for financial incentive in order to insure good work. The reasoning then follows that interest, love for work and a sense of responsibility and accomplishment are not enough to sustain the doctor in his labors. As professionals, can we not, in advance, decide what an adequate yearly income should be or is it really essential that we be entrepreneurs while calling ourselves professionals? Historical reasons have evolved for the fee-for-service system. It could hardly have been done any other way, but it is not decreed in the Ten Commandments or the Bill of Rights. Many doctors in this country work on salary in universities, hospital-based settings, group practice, the military or government positions and are providing good medical care. They are probably as happy, in general, as the average private practitioner. Perhaps the time has come for the medical profession to begin to explore alternate ways to accomplish a change. It is important to consider and examine how the fee-for-service method has been failing us, for alternatives will be adopted, either good or bad.

Notwithstanding the above, in the final analysis, shouldn't the deciding factor be what kind of a practitioner has each doctor become—dedicated, currently informed in his specialty, and conscientious. Assessment of physician competence is being proposed at the present by the American Society of Internal Medicine using peer review of each physician's performance with his patients in his own practice.

If we wish to continue fee-for-service, we must make certain that it is commensurate with and justifiable for the service provided.

C.M.C.

The wisdom of the wise is usually an uncommon degree of common sense.



## Continuing Education for Practicing Physicians

The Community Hospital Education Act was signed into law by Governor Askew following the 1971 Session of the Florida Legislature. The Legislative intent as stated in that Act reads as follows:

"It is the intent of the Legislature that health care services for the citizens of this state be upgraded and that a program for continuing these services be maintained through a plan for community medical education. The program is intended to provide additional outpatient and inpatient services, a continuing supply of highly trained physicians, graduate medical education, and a program for continuing education in professional skills for practicing physicians in the state."

Dr. Richard Hodes, Tampa anesthesiologist and a member of the Florida House of Representatives, was primarily responsible for conceiving and obtaining passage of this legislation.

The Act called for a seven-member council\* appointed by the Governor. That Council is responsible for making recommendations to the Board of Regents for the standards and policies of the use and expenditure of the funds appropriated to the Board of Regents under this Act. For the coming fiscal year an appropriation of \$750,000 has been made, an increase of \$250,000 over that for fiscal year '72-'73. During the past fiscal year all of the available funds were dispersed among the several community hospitals engaged in graduate education. The law specifically prohibits use of these funds in any hospital "under the control of the Board of Regents" which we interpreted to be only the Shands Teaching Hospital in Gainesville. The law further requires that any participating hospital be "qualified for approval by the Council on Medical Education of the AMA," hence those hospitals devoted exclusively to postgraduate education of osteopathic physicians were eliminated. The Council has been chosen likewise to eliminate all hospitals owned by state or federal government.

During the past year some support was made available to a total of 21 hospitals located in 11 different cities providing training for a total of

889 interns and residents. In addition start-up grants were issued to Alachua General Hospital in Gainesville and Tallahassee Memorial Hospital, both of which plan to initiate family practice residencies on July 1, 1973.

Following much deliberation and discussion with a number of people, several categories of grant support were announced early in the last fiscal year. In order to provide some assistance to all programs, as specifically called for in the legislation, \$178,000 was distributed in the form of \$200 per intern or resident on duty on a given census day, August 23, 1972.

The remainder of the funds were made available through a variety of programs such as: (1) In recognition of the recruitment value of having medical students receive short-term exposure in community hospital training programs prior to graduation, matching support at a rate not to exceed \$150 per month, per student. (2) In order to encourage interns and residents to rotate to other locations such as medical centers for brief periods of study of special techniques and perhaps to attend short courses, intern and resident dislocation costs were supported on a matching basis to a maximum of \$350 per month for periods not exceeding three months. (3) A fund was created to help with costs of teaching consultants and visiting lecturers on short-term visits. The original limitation of \$150 per person, per visit has now been amended to a maximum of \$100 per day, per visit. (4) A category of special educational programs was created and competitive applications sought. Programs designed to improve the delivery of health care, especially by primary physicians, were favored in view of their shortages. Applications involving primarily the purchase of hardware have not been encouraged. (5) Finally, the door was left open inviting imaginative and innovative ideas that might not fit into any of the categories but which might contribute significantly to the intent of the legislation.

While much of value has been accomplished in the first year of funded operation of this program, its full potential has by no means been reached. With the added funds available in the coming year, together with a broader awareness of availability and purpose of these funds, it is hoped

\*Frank C. Coleman, M.D., Chairman, Tampa; Thornton Beckner, M.D., Orlando; A. Joseph Henry, M.D., Tallahassee; Emanuel Papper, M.D., Miami; William D. Walklett, M.D., Jacksonville; William C. White, M.D., Pensacola; Mr. Ned Wilford, Lakeland.

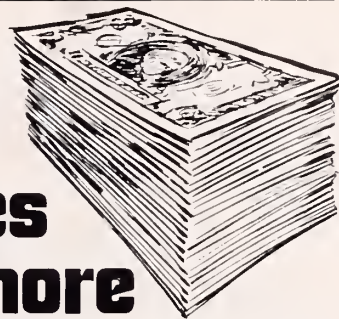
that the number and value of the programs supported can be increased. In particular, it is our hope that greater emphasis can be given to preparing primary care physicians. There are now seven approved Family Practice programs in the state with more being planned. In addition, we believe that efforts directed to emergency room medicine, drug abuse, and other community health problems unique to Florida could be of great value. Finally, one of the clearly stated legislative intents of this Act is continuing education for practicing physicians. It is hoped that in connection with development and improvement of house-officer education in community hospitals can come improved programs for the benefit of attending physicians. Programs designed to this end will be looked upon favorably for participatory funding.

It is apparent that geographic maldistribution and the shortage of primary care physicians are the major concerns for the medical profession in our state. The Community Hospital Education Program has the potential for influence in both of these concerns. But we can only respond to requests originating from those associated with the Community Hospital Training Programs themselves. The participation of all who are interested is earnestly solicited. For further information write: Dr. Kenneth E. Penrod, Staff Director, Community Hospital Education Program, State University System of Florida, Room 201 Collins Building, Tallahassee 32304. Phone 904:488-5443.

Frank C. Coleman, M.D.  
Tampa



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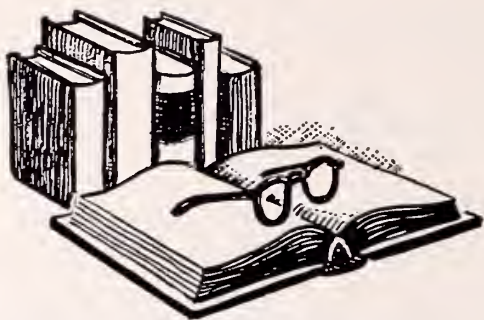


## ORGANIZATION



### W. Jape Taylor, M.D. Receives Hippocratic Award

In ceremonies June 1 on the lawn of the University of Florida's Shands Teaching Hospital, the fifth annual Hippocratic Award for Teaching Excellence was presented to Dr. William Jape Taylor, Chief of the University of Florida College of Medicine's Division of Cardiology. Presenting the award is 1973 Class Chairman, Bayard Miller, of Gainesville. The senior medical students selected Dr. Taylor as "the clinician-teacher who best exemplifies the ideals of Hippocrates, the father of medicine."



## Book Reviews

**Laboratory Medicine Hematology**, Fourth edition by John B. Miale, M.D. 1318 Pp. 1399 illustrations. Price \$27.50. St. Louis, The C. V. Mosby Company, 1972.

It would be a reasonably safe bet to wager that Dr. Miale's Hematology is to be found on the book shelves of the majority of practicing pathologists in the country. His standard text now in its fourth edition—*Laboratory Medicine Hematology*, John B. Miale, M.D., Mosby & Company, \$27.50—is a standard working and reference text and is regarded with almost biblical reverence by pathologists and hematologists alike. This fourth edition, published last fall, embodies certain additions and changes from the previous texts. Pages and plates are more numerous. There is a somewhat more comprehensive review of the reticulo-endothelial system. Current concepts of the activities and functions of the lymphocytes, especially in the area of immune mechanisms, are given considerable attention. The volume suffers, as did its predecessors, with a comparative lack of color photographs or drawings. The book, however, is not an atlas and "ribbon matching" is not encouraged in the field of morphology. Chapters include transfusion of blood, hemostasis and blood coagulation, as well as extensive coverage of the cellular components of blood. The book is, of course, highly recommended.

COURTLANDT D. BERRY, M.D.  
NAPLES, FLORIDA

---

Beware of a half-truth; you may be hearing the wrong half.

**Handbook of Medical Treatment** edited by Milton J. Chatton, M.D. Pp. 648. Price \$6.50. Los Altos, California, Lange Medical Publications, 1972.

What! Another handy book for the back pocket of an intern or resident. At the rate these soft cover books are coming out, the poor house officer will have to carry a rucksack to accommodate them all, but, you can't argue with success. This is the thirteenth edition. In addition, there is an Italian edition, a Turkish edition, and a Spanish edition.

Although this volume is edited by Professor Chatton who also has written four chapters and collaborated on three more, 17 other physicians and a dietitian are represented under "the authors." Their credentials are very impressive.

All systems from Endocrine to Urinary are covered in 10 chapters. Four of the 23 chapters are devoted to Infectious Diseases; the rest deal with miscellaneous subjects such as Psychiatric Disorders, Cancer Chemotherapy, Nutrition, and Fluid and Electrolyte Disorders. Although Dr. Chatton states in the preface that "we have endeavored to incorporate innovations in medical therapy within a book of pocket size by deleting some of the less common disorders" he discusses such disorders as Familial Periodic Paralysis, Leprosy (the only cases I've seen in 30 years of practice were in a leprosarium in the Far East), and Kwashiorkor (which I have yet to see in my office). I would much prefer the author omit these disorders and give more details on what the physician is likely to see in his everyday practice; nevertheless, a great deal of ground is covered in the 648 pages and the index of 27 pages is fairly complete.

Although this volume will never give serious competition to *The Merck Manual*, it is a sort of shorthand version of the Manual and will fill a place on the physician's reference shelf.

ARTHUR FREDERICK SCHIFF, M.D.  
MIAMI



**Within the Gates of Science and Beyond; Science in its Cultural Commitments** by Paul A. Weiss. Pp. 328. Price \$9.95. New York, Hafner Publishing Co., Inc., 197 .

This volume of essays (articles) by a distinguished biologist reflects his thoughts about science in general over the span of a career.

In looking back over this career he states, "... Achievement is marked not so much by what one has learned, but by how one is using that which one has learned, with eyes and mind wide open to the immense range of *terra incognita* in the life sciences and the untapped resources and opportunities for its elucidation and penetration by observation, experiment and theory."

In discussing information and knowledge, he states, "Graded in terms of relevance, not every observation is worth recording; not every record is worth reporting; not every report is worth publishing; and not every publication is worth preserving for eternity, except in sample specimens as in Noah's Ark."

"... the effective pursuit of knowledge is intimately linked to the old virtue of disciplined research morale, which will not countenance the substitution of bigness for greatness, gadgets for intellect, projects for ideas and man-hours for thought, although it must rely to the fullest on technical relief by gadgets and man-hours in those auxiliary services which do not require the intervention of a constructive mind."

Though this volume will not be of general interest to the physician reader, the author's perceptions about science should be engaging for those interested in science in its broader connotations.

F. NORMAN VICKERS, M.D.

The child who is uneducable does not exist  
If he knows you care and love him,  
He will try to please you to the utmost.

Mrs. Catherine Battista  
6th Grade Teacher  
Lindberg Elementary School  
Palisades Park, N. J.

## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**Principles of Clinical Electrocardiography**, 8th Edition, by Melvin J. Goldman, M.D. Pp. 400. Illustrated. Price \$8.00. Los Altos, California, Lange Medical Publications, 1973.

**The Carbo-Calorie Diet** by Donald S. Mart. Pp. 114. Price \$.95. New York, Doubleday & Company, Inc., 1973.

**Is My Baby All Right?** by Virginia Apgar, M.D. and Joan Beck. Pp. 492. Illustrated. Price \$9.95. New York, Trident Press, 1973.

**Family Planning Education, Parenthood and Social Disease Control** by Charles William Hubbard, B.S., M.P.H. Pp. 173. 48 Illustrations. Price \$3.95. St. Louis, The C. V. Mosby Company, 1973.

**Mental Health and Social Change. An Annotated Bibliography** edited by George V. Coelho. Pp. 458. Price \$3. Washington, D. C., U.S. Government Printing Office, 1972.

**Handbook of Pediatrics** by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. Pp. 693. Price \$6.50. Los Altos, California, Lange Medical Publications, 1973.

**Hospitals—A Systems Approach** by Raymon D. Garrett. 224 pages. Illustrated. Price \$12.50. Philadelphia, Auerbach Publishers, Inc., 1973.

**Review of Medical Physiology** by William F. Ganong, M.D. 6th ed. 578 pages. Illustrated. Price \$9.00. Los Altos, California, Lange Medical Publications, 1973.

**Review of Physiological Chemistry**, 14th ed. by Harold A. Harper, Ph.D. 545 pages. Illustrated. Price \$8.50. Los Altos, Calif., Lange Medical Publications, 1973.

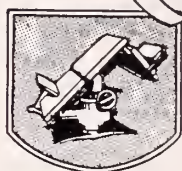
**Synoptic Functional Neuroanatomy** by Wendell J. S. Krieg, Ph.D. 74 pages. Illustrated. Price \$6.00 (cloth), \$5.00 (paper). Evanston, Ill., Brain Books, 1973.



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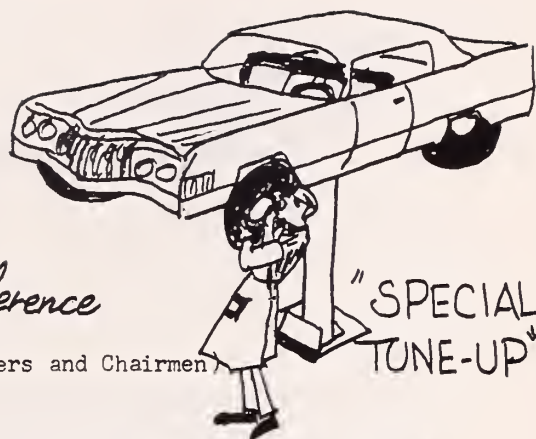


Mrs. Ronald J. Mann, of Miami, worked long and hard during the recent annual meeting in Miami Beach to make the Woman's Auxiliary Seventh Annual Benefit Art show a success and she deserves a lot of applause.

# THE SOUND OF MUSIC



## Woman's Auxiliary Fall Board Meeting and Conference



Doctor (Especially you who are married to Auxiliary Officers and Chairmen)

Putting off a tune-up can cost you plenty!

Remember, a tune-up is good for surer starting, better mileage, peppier performance and it reduces shocks and sparks. You can restore lost power with an expert tune-up. Isn't it time for you to bring your wife into our inspection station where body and mechanical estimates on all makes and models are absolutely free? Our personalized service includes all those extras that count - EXTRA CONSIDERATION, EXTRA ATTENTION and EXTRA KNOW HOW and we guarantee all our tune-ups.

Did your wife get her Spring Check-up?

Was she present at the Americana for Convention?

If your answers are "YES", she is helping to compose her County Auxiliary Melody for this year. When Convention time '74 comes around, 27 Auxiliaries will be singing their "kind of music" with lyrics that tell of their activities during the year. They are to pick out a tune, write the score, pitch the key so that all their members can sing, put in all the sharps and flats, keep the tempo at a moderate pace so that they don't lose anyone and rehearse their melody frequently. I've asked them to put the accent on harmony as they create their "Sound of Music". Now, about that tune-up!

We've reserved the Ponte Vedra Club for the week-end of October 26 - 28 (there are NO football games scheduled for that week-end) and while you get a complete brake adjustment out on the golf course or the tennis court, your wife will be getting her battery charged and her carburetor adjusted. We'll be sending out the check list soon. Watch for it. We want you to bring your model in to us before it is too late.

-----with a song in my heart,

Mrs. Wm. Hugh (Mary Ann) Mathews  
President, WA-FMA

Ponte Vedra Club, Ponte Vedra Beach, Florida





## Letters

Dear Editor:

I am editing a book on renown and notable physicians and their faith.

I am interested in obtaining contributors who have a special knowledge of the faith and/or religion of one or more notable and outstanding physicians. I am considering such physicians as Sir William Osler and Sir William Fleming; however, the notable physicians could still be alive.

Anyone interested in this project or who would suggest renown physicians to write about may contact me at the following address:

Claude A. Frazier, M.D.  
4-C Doctor's Park  
Asheville, N. C. 28801

Thank you in advance.

CLAUDE A. FRAZIER, M.D.

Dear Editor:

In reply to the "Someday" of your editorial in the April JFMA on automobile safety devices—that is now and ten years ago. Seat belts and shoulder straps will save thousands of lives. Mandatory wearing of seat belts (and shoulder straps) looks like an excellent prospect. Shoulder straps without seat belts are lethal and decapitation has occurred. I agree, airbags are hazardous in themselves.

T. Norley, M.D.  
West Palm Beach

The most highly inflammable kind of wood  
Is the chip on the shoulder.

# Rondomycin<sup>®</sup>

## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE:** Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** "Rondomycin" (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev 6/73



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## Deaths

**Fanelli, Mary Jo**, St. Petersburg; born 1940; University of Miami, 1965; member AMA; died February 8, 1973.

**Carefoot, Evison I.**, Jacksonville; born 1889; Georgia College of Eclectic Medicine & Surgery, 1911; member AMA; died April 26, 1973.

**Dann, T. Philip**, St. Petersburg; born 1919; Louisiana State U., 1943; member AMA; died March 26, 1973.

**Judd, Allyn F.**, Delray Beach; born 1923; University of Maryland, 1947; member AMA; died February 7, 1973.

**Lageyre, Guillermo**, Miami; born 1916; Havana Medical School, 1943; member AMA; died December 24, 1972.

**Miller, Redden L.**, Graceville; born 1885; Atlanta College of P & S, 1910; member AMA; died January 10, 1973.

**Pilliod, John V.**, Fort Myers; born 1898; Cincinnati Medical School, 1921; member AMA; died January 10, 1973.

**Scanlon, John J.**, Winter Garden; born 1911; Creighton U., 1935; member AMA; died May 21, 1973.

**Smith, William K.**, Clermont; born 1913; Vanderbilt University, 1943; member AMA; died January 21, 1973.

**Stoddard, Guy R.**, Miami Beach; born 1910; George Washington University, 1939; member AMA; died February 5, 1973.

**Waite, Ellsworth F.**, Daytona Beach; born 1905; Boston U., 1936; member AMA; died April 14, 1973.

**Whiddon, Lester L.**, Fort Pierce; born 1890; Emory U., 1916; member AMA; died May 1, 1973.



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# MEETINGS

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National and Regional  
Meetings Held in Florida

## AUGUST

- 16-18 Postgraduate Obstetric-Pediatric Seminar, Pier 66 Hotel, Ft. Lauderdale. For information: A. F. Caraway, M.D., Box 210, Jacksonville 32201.

## SEPTEMBER

- 27-29 Emergency Medicine: Cardiopulmonary Resuscitation and Pediatrics, Desert Inn, Daytona Beach. For information: Bruce Webster, M.D., 945 Lakeview Dr., Winter Park 32789.

## OCTOBER

- 12-14 Florida Region of American College of Physicians and Florida Society of Internal Medicine, Innisbrook, Tarpon Springs. For information: Chester Cassel, M.D., 1150 N.W. 14th St., Miami 33136.
- 26-27 Postgraduate Course in Otolaryngology for the Family Practitioner, Playboy Plaza, Miami Beach. For information: Bruce W. Weissman, M.D., Box 875, Biscayne Annex, Miami 33152.

## NOVEMBER

- 22 Jacksonville Hospitals Education Program Basic Science Course, Alumni Auditorium, University Hospital, Jacksonville. For information: Herbert A. Burke Jr., M.D., 655 W. 8th St., Jacksonville 32209.

1974

## JANUARY

- 2- 5 Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Eden Roc Hotel, Miami Beach. For information: Div. of Continuing Education, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

## FEBRUARY

- 22-24 Pediatric Dermatology Seminary, Fontainebleau Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

## SEPTEMBER

- 16-20 American Academy of Ophthalmology and Otolaryngology, Convention Center, Dallas, Texas. For information: C. M. Kos, M.D., 15 Second St., S.W., Rochester, Minn. 55901.
- 27-29 National Conference on Cancer of the Colon and Rectum, sponsored by American Cancer Society, Americana Hotel, Miami Beach. Info.: Sidney L. Arje, M.D. American Cancer Society, 219 East 42nd Street, New York 10017.

## OCTOBER

- 1- 5 American Association for Laboratory Animal Science, Americana Hotel, Miami Beach. Exec. Sec.: Mr. Joseph Garvey, 2317 West Jefferson Street, Joliet, Illinois 60435.
- 11-13 American Society for Colposcopy and Colpomicroscopy, Sonesta Beach Hotel, Key Biscayne. Pro. Dir.: Adolfo C. Corzo, Symposia International, P. O. Box 580, Tujunga, Calif. 91042.
- 20-21 American Association for Hand Surgery, Diplomat Hotel, Hollywood. Sec.: Kim K. Lie, M.D., 27500 Hoover Road, Warren, Michigan 48093.
- 21-26 American Society of Maxillofacial Surgeons, Diplomat Resorts, Hollywood. Sec.-Treas.: Samuel Shatkin, M.D., 50 High Street, Buffalo, N.Y. 14203.
- 21-26 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Hollywood. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

## NOVEMBER

- 5- 9 Gerontological Society, Miami Beach. Exec. Dir.: Mr. Edwin Kaskowitz, One DuPont Circle, Washington, D. C. 20036.
- 7-10 American Medical Women's Association, Palm Beach. Exec. Dir.: Mrs. Gertrude Conroy, 1740 Broadway, New York 10019.
- 11-16 American Association of Blood Banks, Miami Beach. Office Mgr.: Miss Lois J. James, 1828 "L" Street, N.W., Washington, D. C. 20036.

Next FMA Annual Meeting: May 8-12, 1974, Hollywood

## Classified Ads

### physicians wanted

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**PENSACOLA—ESCAMBIA COUNTY,** Northwest Gulf coast: Associate desired in Preventive Medicine-oriented family practice emphasizing care of the total person. Three open general hospitals in area with intern-resident program and continuing educational program. Percentage with guaranteed salary first year, full partnership thereafter. Contact Joseph P. Gentile, M.D., P.A., 5728 North Davis Highway, Pensacola 32503. Phone (904) 477-5457.

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**MULTISPECIALTY MEDICAL COMPLEX** — Urgent need for board certified/eligible OB under 40 to take over existing practice, near hospital, excellent opportunity for fast start in thriving community. Contact Glen P. Musselman, M.D., P.O. Box 1177, Cocoa Beach, Florida 32931. Phone (305) 783-2292.

**UNIQUE OPPORTUNITY FOR OPHTHALMOLOGIST** to share office space with another doctor and Lugenex, Inc. For further details contact Paul G. Brown, Vice President, Palm Springs Professional Building, 3175 Congress Avenue, Lake Worth, Florida 33460. Phone (305) 968-2315

**PEDIATRICIAN FOR ASSOCIATION:** With pediatrician in busy central Florida area. Salary first year, percentage and partnership to follow. Florida license required. Write C-584, P.O. Box 2411, Jacksonville, Florida 32203.

**WANTED: GENERAL SURGEON,** Board certified or eligible, with Florida license. North Central Florida community inland, good financial opportunity, good hospitals, good schools. Moderate salary 1st year leading to partnership if mutually satisfactory by 4th year. Send details with biographical data. Write C-605, P.O. Box 2411, Jacksonville, Florida 32203.

**PHYSICIANS WANTED:** General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 East 25th Street, Hialeah, Florida 33013. Phone (305) 696-0842.

**OB-GYN AND PEDIATRICIAN URGENTLY NEEDED** in expanding south central Florida town. All sports. 60 miles from coasts. GP. carrying load alone forming clinic. Florida license necessary. Call (813) 983-8531.

**WANTED:** Young G. P. or internist to associate with young established P.A.'D G.P. in Fort Lauderdale area. Four day week. Alternate three day weekends. Good pay and benefits. Call or write to Virgil R. Rizzo, M.D., 4100 South Hospital Drive, Plantation, Florida 33313 or phone 583-7267 anytime.



## Miscellaneous

**ADDITIONAL PHYSICIANS URGENTLY NEEDED:** GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

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# JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

VOL. 60, NO. 9



WDS

SEPTEMBER 1973

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154





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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To help you manage excessive psychic tension



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SEPTEMBER COVER—Among the great in medicine was Antonj Van Leeuwenhoek (1632-1723 A.D.) The father of microscopy, he ground his own lenses—made his own microscopes and opened a door to the fascinating tiny world which lies beyond macroscopic vision. He had an insatiable curiosity and his explorations led him to a thorough demonstration of the capillary circulation, completing William Harvey's postulates. This drawing and those to follow courtesy of Watson Clinic, Lakeland.

## Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. Indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

# BACTRIM<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



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Nutley, N.J. 07110



## President's Page



### Blue Shield - Jacksonville

From 1944 to September 1, 1946 many Florida Medical Association members collectively donated \$20,000 to create the first total health insurance program in Florida. This attempt to spread the increasing cost of health care delivery was in answer to a National Health Insurance Program, sponsored in Congress by the then Senator Claude Pepper. Commercial carriers soon followed suit. Today, over 700 carriers offer health insurance in our state.

Blue Shield of Florida has grown to the point of having 1.7 million subscribers. It does \$60 million in business annually, has \$34 million in assets, and handles some 30,000 claims each month.

While the above is history, it is important to know that health insurance in Florida was *originated* by doctors. Blue Shield, the resulting company, has voting acting membership made up almost entirely of doctors. As such, it can be *used* by doctors to mold a continuously improving program to fit the needs of health care.

Bob Zellner once said "The Achilles heel of Blue Shield is its tendency toward preoccupation of each physician for himself." However, this weakness, if it exists, is countered by the diverse management structure of Blue Shield. Overall management of Blue Shield is the responsibility of the Board, the members of which are elected each year by the House of Delegates. While the group has a preponderance of doctors, it also comprises bankers, lawyers, real estate executives, and other entrepreneurs who help provide the total management perspective required for a business of this size.

To provide further objectivity, and valuable inputs from every specialty of organized medicine, the Committee of 17 stands at a distance and advises the Board. By continuously evaluating philosophies, motives, ideals, and goals, they frequently make contributions which have a decided and beneficial effect upon both Blue Shield and the Florida Medical Association.

My six years ending in May, 1973 on the Blue Shield Board, with its many highly qualified and dedicated members, has been a very gratifying and rewarding experience. During this period, also, I gained insight into the strengths and weaknesses of the Blue Shield organization. At this point, I consider myself its strongest critic—and its strongest supporter.

I believe that our present organizational concept includes the best techniques of good business and free enterprise, combined with the checks and balances of good government. The Blue Shield Board is elected by members of the House of Delegates, who, in turn, are elected by the individual doctors. The Committee of 17 provides expert advice, and the FMA Board reviews the overall operation. All of these officials serve Florida Medicine at the pleasure of you, the physician.

As one reflects on the development of Blue Shield over the past twenty-odd years, he concludes that maybe Senator Pepper did us a favor by raising the Florida doctor from his apathy and forcing him to worry about the economics of his patient. He created a company which not only was the first to provide patient protection, but also is the only one which can be improved by the person most uniquely in a position to see the need for improvement—the patient's physician.

The philosophy of Blue Shield has not changed since its beginning in 1946. The subscriber is still the first and most important responsibility. The day we forget or neglect this responsibility should be the day that national health insurance is initiated.

Blue Shield is a grass roots organization. *The House of Delegates*, the *Blue Shield Board*, and the *Committee of 17* are nothing more than management tools. If they are to succeed in implementing our philosophy, meeting our responsibilities, and improving our service, they must have your advice and assistance. Use them to let your feelings and ideas be known—because, after all, Blue Shield does belong to you, the Florida doctor.

★ FOR CORRECTION  
SEE P. 23 #10



# Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

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**the compatible vasodilator...  
no treatment conflicts reported**

The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

**Possibly Effective:**

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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734017

1. Gertler, M. M., et al.: Geriatrics 25:134-148 (May) 1970.

**Mead Johnson** LABORATORIES

# What's on your patient's face...

may be more important than his chief complaint

Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

\*Data on file,  
Hoffmann-La Roche  
Inc., Nutley, N.J





# The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

## Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

## Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

## Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

**Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# This patient's lesions were resolved with

# Efudex®

# fluorouracil/Roche®

## 5% cream/solution...a Roche exclusive

# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combination products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# **M-M-R<sup>\*</sup>**

## **(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)**

Single-dose vials

**M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.**

### **MSD suggested immunization schedule for well babies**

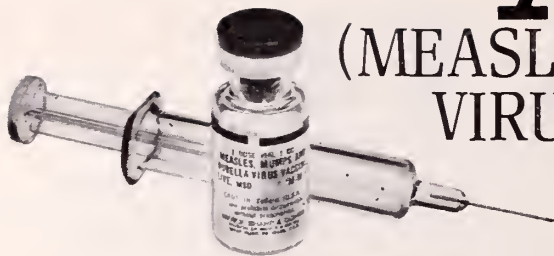
<b>Age</b>	<b>Vaccine(s)</b>
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT <sup>1</sup>
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
<b>12 MONTHS</b>	<b>M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)</b>

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

\*Trademark of Merck & Co., Inc.

**For a brief summary of prescribing information, please see following page.**



# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** Fever, rash; mild local reaction such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia or purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccine may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult males and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

**MSD**  
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hunting range but  
increased blood  
pressure in  
hemorrhoidal  
veins**

to help ease  
acute symptoms of hemorrhoids

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Hemorrhoidal Suppositories with Hydrocortisone Acetate. On your Rx only!  
Each suppository contains hydrocortisone acetate 10 mg, bismuth subgallate 2.25%;  
bismuth resorcin compound 1.75%; benzyl benzoate 1.2%; Peruvian balsam 1.8%; zinc  
oxide 11.0%; and boric acid 5.0%; plus the following inactive ingredients: bismuth  
subiodide, calcium phosphate, and coloring in a bland hydrogenated  
vegetable oil base containing cocoa butter.

for long-term  
patient  
comfort

# Anusol<sup>®</sup>

Suppositories and Ointment Each suppository or gram of  
ointment contains the active ingredients of an Anusol-HC  
suppository minus the hydrocortisone.

**Warner/Chilcott**



Division,  
Warner-Lambert Company  
Morris Plains, New Jersey  
07950

ANGP-35

**Precaution**  
Prolonged or excessive  
use of Anusol-HC might  
produce systemic  
corticosteroid effects.

Symptomatic relief should  
not delay definitive  
diagnosis or treatment.

**Dosage and Administration**

Anusol-HC: One suppository  
in the morning and one at  
bedtime for 3 to 6 days  
or until the inflammation  
subsides.

Regular Anusol: one  
suppository in the morning,  
one at bedtime, and one  
immediately following each  
evacuation.

## Medical News

### Sweden Honors Florida M.D.

An honorary Doctor of Medicine degree was awarded in Uppsala, Sweden to Dr. Lester Reynold Dragstedt of Gainesville.

Dr. Dragstedt, research professor of surgery and professor of physiology with the University of Florida College of Medicine, is known worldwide as a major contributor to better understanding the cause of various types of ulcers and to developing better means of treatment. He also is known as a pioneer and innovator in surgery, and for his major role in surgical education. Many of his former students now fill major medical positions with health centers around the nation.



DR. DRAGSTEDT

### Miami U. Gets Associate Dean

Mark A. Freedman, M.D., a nationally known authority on hospitals, will join the University of Miami School of Medicine in September as Associate Dean in charge of hospital affairs.

Dr. Freedman, who received his M.D. degree from the Ohio State University College of Medicine in 1938, will serve as a liaison between the medical school and affiliated hospitals.

### ACP Meeting in Florida

The Florida region of the American College of Physicians and the Florida Society of Internal Medicine will have their annual meeting in Innisbrook, Tarpon Springs, October 12-14.

Information may be obtained from Chester Cassel, M.D., ACP Governor for Florida, 1150 N.W. 14th Street, Miami, Fla. 33136.

### Geriatrics Society Elects

Two members of the Florida Medical Association have been elected to office in the American Geriatrics Society.

Charles E. Lyght, M.D., of Oklawaha, was named Treasurer and Charles R. Beber, M.D., was elected to the Board of Directors during the Society's 30th Annual Meeting in Beverly Hills, Calif.

### HEW Grants Announced

Two Florida hospitals are among 51 throughout the nation to share in \$5 million in federal grants to train physicians in family practice.

St. Vincent's Hospital of Jacksonville and Jackson Memorial Hospital in Miami will receive about \$87,000 each under allocations announced by the Division of Physician and Health Professions Education of the National Institutes of Health.

Federal support to public or private nonprofit hospitals for training in family practice was authorized by the Comprehensive Health Manpower Training Act of 1971.



## Ob.-Gyn. Chair Endowed

A third chair of obstetrics and gynecology at the University of Florida College of Medicine has been endowed through private contributions in the amount of more than \$843,000.

The chair is named for Harry Prystowsky, M.D., who served as Professor and Chairman of the Department of Obstetrics and Gynecology from 1958 until his recent departure to become Provost of the Medical Center and Dean of the College of Medicine at the Milton S. Hershey Medical Center, Pennsylvania State University.

A member of the Florida Medical Association, Dr. Prystowsky has had a distinguished career. At age 32, he was America's youngest full professor and chairman of a department of obstetrics and gynecology. Two years later, he was selected by the U.S. Junior Chamber of Commerce as one of America's Ten Outstanding Young men for his research in the interchange of basic chemicals between mother and unborn child.

## Family Practice Rounds at St. Joseph's Hospital in Tampa

A section in Family Practice at St. Joseph's Hospital in Tampa has for a three-year period been holding weekly teaching rounds. The material comes from the patients of those physicians in Family Practice who participate in the presentation, discussion and disposition of the problems as presented. The program has been conducted by Kenneth E. McIntyre, M.D., Director of Medical Education. In the past several months he has been assisted by Dr. Donald MacQuorquodale, representing the University of South Florida School of Medicine. The American Academy of Family Physicians has approved the rounds for Category I credit. Any physician in this area who wishes to participate for credit, may do so. The rounds are held each Thursday morning at 7:30 a.m.

## New Editor Appointed for Southern Medical Journal

Harris D. Riley Jr., M.D., professor of pediatrics and head of the Department of Pediatrics, University of Oklahoma College of Medicine and pediatrician-in-chief of Children's Memorial Hospital, University of Oklahoma Health Sciences Center, Oklahoma City, Okla. has been named editor of the *Southern Medical Journal*.

Dr. Riley has previously served as pediatric editor, assistant and associate editor of the *Journal*, one of the nation's top medical publications. Published monthly by the Southern Medical Association (SMA), at the headquarters in Birmingham, Ala.

## Obligation of Admitting Physician

The admitting physician in a mental health receiving facility is responsible for the care of any person eligible for admission even though the center may be overcrowded, Florida's Attorney General has ruled.

Atty. Gen. Robert L. Shevin rendered an opinion in response to an inquiry raised by State Rep. F. Eugene Tubbs, M.D.

"The admitting physician," Shevin wrote, "must make a good faith effort to comply with the provisions of the Florida Mental Health Act . . . in the administering of care to such eligible individuals until the receiving facility's overload is eased or a transfer of the patient to another receiving facility is accomplished."

## Endocrinology Symposium

The St. Vincent's Medical Center, in conjunction with JHEP, presents "Endocrinology for Physicians," September 15-16, 1973. Leading Professors of Endocrinology throughout the United States will cover most recent advances and clinical applications. Information may be obtained by writing Yank D. Coble Jr., M.D., 2700 Riverside Avenue, Jacksonville 32205.

—an everyday

# ALLERGY



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Since patients with atopic diseases have in common an inherited predisposition to develop sensitivity, the Family Practice Physician usually sees these patients first.

To assist in identifying the causative factors and treat them specifically, Barry has designed a Proven Service for the Family Physician.

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### PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

**Precautions.** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

**How Supplied.** Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

**ROERIG **

A division of Pfizer Pharmaceuticals  
New York, New York 10017



# Clean Sweep



## with a single dose of Antiminth

(pyrantel pamoate) ORAL SUSPENSION

Highly effective against  
pinworm and roundworm

Non-staining to teeth  
or oral mucosa on ingestion, to  
stools, clothing, linen

Simple dosage with a  
single-dose regimen: 1 cc. per  
10-lb. body weight (1 tsp./50 lb.;  
maximum dose, 4 tsp.)

Well-tolerated, based on  
clinical studies\*

Pleasant-tasting, easy-to-  
take, caramel-flavored oral  
suspension

Economical, because one  
prescription can treat the entire  
family

**ROERIG** *Pfizer*

A division of Pfizer Pharmaceuticals  
New York, New York 10017

# ANTIMINTH<sup>®</sup>

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

While Antiminth is highly effective against pinworms and roundworms, the illustration is not meant to imply 100% efficacy.  
\*Data on file at Roerig. Please see prescribing information on facing page.

**Because you  
practice  
medicine in the  
Sunshine State...**





**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis**

# **adjunctive Librax®**



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

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# DARVOCET-N<sup>®</sup> TABLETS

50 mg. propoxyphene napsylate  
and 325 mg. acetaminophen



*Additional information available to the profession on request.*  
Eli Lilly and Company, Indianapolis, Indiana 46206

300104





## The Vagaries of Historical Data

THOMAS C. WICKENDEN, M.D.

**Abstract:** College students in Florida with their increased mobility and diverse fields of interest, become exposed to a wide range of infectious agents. Diagnosis of these illnesses requires skill in sifting the historical data and following leads with appropriate diagnostic tests. Solution of three typical problem cases is presented. Concern is raised about the need for better control and guidelines for the more esoteric activities of this large age group.

The keystone, in truth the very heart of successful and rewarding diagnostic solutions, often lies within the thoughtfully recorded and at times doggedly searched for details of historical events preceding illness.

The present day university students present an unusual challenge. Their unprecedented mobility whether by plane, Porsche, panel truck or hitchhiking, places them not only in the major cities of the Western Hemisphere but in its remote rural byways as well. Their range of interests, hobbies and the wide variety of fields of study lead them to caves, sinkholes, abandoned mine pits, underwater grottoes, swamps, woods, fields, mountains, beaches, coral reefs and city ghettos.

This leads to historical data beyond the fancy and whimsy of even television serial writers. It

confronts the physician with an ever widening range of diagnostic possibilities. This places great emphasis on the appropriate use of skin tests, serum agglutination and complement fixation tests, blood tests and cultures, spinal fluid examinations and various visceral organ chemistry function studies. A high index of suspicion is all-important. The following are three such challenging cases.

### Report of Cases

**Case 1.**—A 29-year-old Marine Corps veteran was admitted to the Infirmary 10-8-72 with chief complaints of violent chills, fever, marked photophobia, severe headache and exhaustion. His illness began four weeks previously when fairly severe suboccipital headaches developed, occurring about every third day in the late afternoon. These gradually increased in frequency and severity to every day. Three weeks prior to admission chills and fever followed by drenching sweats began accompanying the severe headaches. He obtained some relief from aspirins every six hours daily, although his thirst became almost insatiable.

His history revealed residence on Guam for a year at age 11, otherwise he had not left the country but lived in Florida except one year previously he spent 6 weeks at Quantico, Virginia, in the field frequently being bitten by mosquitoes in a Marine Officer Training Program. After that he returned to Florida. Seven months previously and until one month before admission he was employed as a lab technician by the University of Florida Dental College. He helped make pig embryo toothbud slides. His job was to visit a local slaughter house and obtain pig embryos. He did not wear gloves when he handled them. Three weeks before admission he went to rural Arkansas for a week, working outside on an old building where mosquitoes were a constant problem. At that time he had sexual contact with a casual acquaintance and since then a mild dysuria without urethral discharge or arthritis. In

four weeks he also had a mild nonproductive cough and lost approximately 30 pounds.

On admission the patient was shaking violently with a temperature of 103.4 and a pulse rate of 112. He was hollow-eyed, dehydrated and intolerant of light. His neck was supple. There was no rash; ENT examination results were negative; no adenopathy was present; the chest was clear; and the heart showed only tachycardia, no murmurs. On abdominal examination a very tender spleen descended with deep inspiration. Thick and thin blood smears were prepared, as well as aerobic and anaerobic blood cultures. The admitting diagnosis was malaria. Although no plasmodia were identified on the smears, the severity of his illness prompted the decision to start chloroquine therapy. The laboratory reported WBC of 3,700, hemoglobin 14 gm, hematocrit 45% with a differential count of 65 segmented cells, 5 bands and 30 lymphocytes. He had a negative monoscreen test and negative urinalysis. The blood culture showed no growth. His hospital course was stormy with daily temperature elevations to 103, 104.2 and 102 on subsequent days. The splenic enlargement and tenderness decreased.

On the fourth day he was transferred to the Veterans Administration Hospital in Gainesville with the diagnosis of fever of unknown origin or possibly chloroquine-resistant malaria. On admission there the only positive finding was a tachycardia of 120. The laboratory data included normal white count, sedimentation rate, hematocrit; the creatinine was 1.4, alkaline phosphatase 23.3, LDH 270, SGOT 146, SGPT 260, ASO titer 125 Todd units, normal urinalysis and culture, negative monoscreening and cold agglutinins, normal protein electrophoresis, BUN, FBC, electrolytes, amylase, bilirubin, prothrombin time, VDRL, and rheumatoid agglutination. Afternoon temperatures continued to spike around 104. Smears showed no malaria parasites. Penile swab was negative. Echo encephalogram, lateral skull x-ray, chest x-ray and lumbar punctures were all normal. A brain scan was normal. Sternal bone marrow was aspirated. Febrile agglutinins were negative for salmonella, paratyphoid and Proteus groups. The titer for typhoid H was positive at 1:40, for *P. tularensis* 1:160, for *Brucella abortus* positive at 1:1280 and for *B. suis* positive at 1:2560. Therapy was immediately begun with tetracycline 500 mg qid for a three week period, intramuscular streptomycin 500 mg bid for two weeks, and prednisone 20 mg q12h for one week. No further temperature elevations occurred.

Final diagnosis: Brucellosis suis.

Case 2.—A 25-year-old white male was well until nine days before admission to the Infirmary on 12-11-72. His chief complaints were persistent headache, photophobia, nonproductive cough and dyspnea. The illness began with dull headaches which became persistent, located behind the eyes, and aggravated by eye movement and exposure to light. Accompanying this were occasional elevations of temperature (recorded) without chills, temperatures typically by late afternoon of 101 or 102 with marked anorexia, although no nausea or vomiting or diarrhea. On the fourth day of this illness he was seen in the Student Health Center by appointment with chief complaints of persistent headache, anorexia and dark urine. History revealed that he had lived in Rhode Island, Corpus Christi, Texas, Adak, Alaska (Aleutian Islands) for two years, and Key West, Florida. For several years he has had petit mal controlled well with phenobarbital. For the last seven months he had a part time job as a surveyor's assistant, spending the entire working time in the surrounding countryside. He had not handled any sick or dead animals, but had seen on numerous occasions decomposing cattle in ravines. He remembers seeing no ticks. His chief hobbies have been snorkeling and cave exploration. Three weeks before this illness began he had developed a severe upper respiratory infection after diving without scuba equipment but with lights to explore some underwater caves near Newberry, Florida. He had become chilled and exhausted. Eight days before his headaches began he had explored several above ground caves, including "Crab Cave" near Newberry, where parts of the cave floor were covered by bat guano.

Physical examination revealed a moderately ill young man with no rash, temperature 100.6, no signs of upper respiratory infection, his neck was supple, eye fundi normal and no adenopathy was present. ENT examination revealed no abnormalities. The lungs were clear, heart demonstrated no murmurs; there were no splenomegaly, liver enlargement nor tenderness. His blood pressure was 130/80. The tentative diagnosis was viremia with infectious hepatitis, possibly aseptic meningitis or rickettsial disease to be ruled out. Laboratory work revealed a urine negative for bile, SGOT 24, SGPT 41, alkaline phosphatase 12 Bodansky units. On the sixth day of illness he returned with the same complaints, namely a low grade headache relieved by mild analgesics and an increasing nonproductive cough without chest pain. There was no jaundice. The liver and spleen were not enlarged. The lung fields were clear. On the ninth day the only new complaints were marked fatigue and dyspnea. On physical examination fine crepitant rales were heard throughout all lung fields.

He was admitted with the tentative diagnosis of primary atypical pneumonia. His temperature was 99.6, pulse rate varied from 96 to 124 and respirations from 18 to 22. There was a slight cyanosis of the lips and nail beds. The patient was dyspneic at rest with a paroxysmal nonproductive cough. He was placed on erythromycin and expectorant cough syrup. The laboratory reported 8,300 WBC with normal distribution and normal urinalysis. Result of sputum examination for acid fast bacilli was negative. His heterophile antibody titer was 1:56, cold agglutinins 1:4. The chest x-ray revealed a severe diffuse disease composed of small miliary-like spread, such as tuberculosis. In addition, the hila were obscured bilaterally by adenopathy suggestive of sarcoidosis with superimposed upper respiratory infection. For the first three hospital days he had late afternoon temperatures of 100.4, 100 and 99.4 respectively. The cyanosis, dyspnea and lung physical findings slowly cleared. On the third hospital day skin tests with middle strength PPD for tuberculosis and coccidioidin for coccidioidomycosis proved negative, but for histoplasmosis there was a markedly positive reaction with 10 mm of induration and erythema. Erythromycin was discontinued. Repeat chest x-ray on the fifth hospital day showed 50% clearing. The patient was discharged asymptomatic at rest on the sixth day when the infirmary was closed for the end of the school term. Serum was sent for complement fixation tests for histoplasmosis and fungal cultures were begun.

Final diagnosis: Acute histoplasmosis.

Case 3.—A 25-year-old white male graduate student was first seen with a one week history of fever, chills, headache and extreme thirst. His graduate field work took him frequently into ponds and marshes of southern Florida where he trapped and handled wild ducks. Three weeks before this illness began his pet dog had leptospirosis and was destroyed, although no confirmatory laboratory studies were done. Five days before onset he had caught and butchered a wild hog.

Physical examination revealed a temperature of 102.4, mild discomfort on neck flexion and mild conjunctival injection. There were transient fine rales at the right lung base. No other abnormalities were noted.

His CBC and urinalysis were within normal limits. Blood and stool cultures were negative. The ESR was 26 mm/hr corrected. Heterophile antibodies were absent. Lumbar puncture revealed normal pressures, but 58 mononuclear cells per ml with protein content of 23 mg% and sugar 42 mg%. Cultures for bacteria and fungi were negative. Chest x-ray revealed blunting of the right costophrenic angle. PPD and histoplasmin skin tests were negative. After the initial cultures were obtained, treatment with ampicillin 2 gm per day was started. Fever and headache persisted for four days with diminishing intensity. On day five, 12 days after onset of illness, the student returned to classes. Hospitalization was avoided by having his wife record his temperature at home and assist him to the outpatient clinic for daily evaluation.

Paired sera for serological tests for typhoid, brucellosis, psittacosis and leptospirosis were collected on the first day



he was seen and the ninth day. All were negative except for leptospirosis. This titer rose from negative to positive in all four antigenic sera type pools; quantitative titers increased to 1:50 for *Leptospira icterohaemorrhagiae* and to 1:100 for *L. canicola*.

### Discussion

Beyond the identification and treatment of these diverse illnesses lies the question of the responsibility of the Student Health Services physician in preventive measures. Should more positive guidelines be offered and should certain recreational activity be actively discouraged? Do the vertebral compression fractures, internal knee injuries and fractured ankles of sky diving enthusiasts make this sport too traumatic? The limit of physical abnormalities for scuba divers has been well stated, but should scuba divers be outlawed from diving in mine shafts and springs where tragic drownings have already occurred? Should spelunkers be protected with antirabies vaccine? Should a cave explorer with a negative histoplasmosis skin test be warned away from caves known to harbor bats carrying *Histoplasma capsulatum*?

For example, in case 1 the use of disposable rubber gloves when handling the fetal pigs would have prevented the entrance of *Brucella* bacteria into skin scratches or abrasions. The avoidance of

disturbing infected bat guano in case 2 and the wearing of a protective industrial type respiratory mask would have lessened the inhalation of large quantities of histoplasmosis fungus. The likely entrance through a skin break of the *Leptospira* of leptospirosis from dog urine in the last case demonstrates the necessity of caution and care in handling sick animals.

The ever widening range of activities of our students, whether in interest groups, study field trips or part-time jobs, demands our thoughtful scrutiny and guidance.

### Acknowledgement

The author is grateful to Dr. W. J. Coggins, Director of Student Health Service, University of Florida, Gainesville, for the details of case 3.

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# Tardive Dyskinesias from the Major Tranquilizers

WILLIAM E. THORNTON, M.D.  
AND BONNIE PRAY THORNTON, R.N.

**Abstract:** Tardive dyskinesias from the major tranquilizers, including the phenothiazines, thioxanthenes, and butyrophenones, represent a potentially serious and sometimes irreversible neurological side effect. Two cases of this neurological effect are described. In each case, the appropriateness of a major tranquilizer as the drug of choice is questionable. A history of the syndrome, and its description is provided and discussed. The therapeutic approaches which have been tried are numerous and generally unsuccessful. There is some evidence to suggest that the common practice of combining antiparkinson drugs with the major tranquilizers may decrease the threshold for tardive dyskinesias and worsen the condition. Preventive recommendations are provided, the foremost being a conscious awareness of its potential onset.

In May 1972 the Food and Drug Administration sent a letter to all phenothiazine manufacturers requiring that they adopt a more specific warning concerning tardive dyskinesia. The revision has occurred and states: "There is no known effective treatment." During their 20 year history, the phenothiazines have enjoyed a progressive increase in use and are believed to represent a major milestone in the history of psychiatric treatment. Few physicians, including many psychiatrists, are able to enumerate the side effects known to occur with these drugs. Several caused considerable alarm when first noted; however, the alarm has been often followed by reassurance when the reversibility of the undesirable complications was established. Now one exception stands out; its significance is uncertain, namely, tardive dyskinesia.

In the past six months we have seen two cases. The first was a 46-year-old woman who holds a masters degree in chemistry. She had been on Thorazine 50 mg. h.s. for approximately 2½

years. There was no history of previous psychiatric illness. She used the drug specifically for its hypnotic effects. An episode of acute alcohol intoxication prompted her being hospitalized, during which time the Thorazine was discontinued. On the day following discontinuation uncontrollable and persistent movements of her tongue developed accompanied by grimacing facial expressions. The condition was believed to be severe. The patient suffered social embarrassment and was both frightened and depressed. No medications were given and fortunately, after 16 weeks, the symptoms disappeared.

Our second case was of milder degree. A 42-year-old married woman who was severely depressed had been taking 7.5 mg. of Permitil daily for 2 years. When the Permitil was discontinued so that antidepressants could be given, uncontrollable tongue movements immediately developed which could be concealed from view but represented a great source of frustration and eventually pain. By placing her back on 15 mg. Permitil daily, we could remove the dyskinesia. After 22 weeks of receiving only Tofranil, the movements ceased.

According to a significant body of neuro-psychopharmacologic literature and opinion, these two patients are fortunate. In our opinion both were not on the drugs of choice and in each instance, if the phenothiazines had been continued, may have suffered irreversible neurologic damage.

## Clinical Reports

In 1960, Kruse described persistent muscular restlessness after phenothiazine treatment in three cases.<sup>1</sup> As early as 1956 Ey, Faure and Rappard reported persistence of extrapyramidal signs after the cessation of treatment with chlorpromazine, and Hall, Jackson, and Swain noted that six of their patients showed parkinsonism after the termination of phenothiazine treatment.<sup>2, 3</sup>

During the next ten years a steady increase of published reports appeared describing this new



neurologic complication, most commonly referred to as tardive dyskinesia or persistent dyskinesia.

In 1966 Ayd published a definitive description and summary of the syndrome.<sup>4, 5</sup> Anyone of the major tranquilizers may be responsible including phenothiazines, thioxanthenes, and butyrophenones. Regardless of the responsible drug, the symptoms are characteristic and uniform with some individual differences only in detail. The movements are primarily choreiform and the facial, lingual, and mandibular muscle groups are primarily affected. As the syndrome progresses the extremities are involved with akathisia and even hemiballistic hyperkinesias. In the early phases, with the mouth opened, the tongue rhythmically moves backward and forward and sometimes laterally. As the disorder progresses, the tongue protrudes and retracts between the lips and teeth. The lips are incessantly chewing with suction motions, and puckering and pursing. When the facial muscles become involved there is grimacing and marked contortions of the face. The interpersonal embarrassment is considerable as is the concomitant social impairment.

Clinical observations include the onset in individuals who have been maintained on these drugs for no less than several months.<sup>4</sup> The onset is insidious with no apparent correlation to dosage. Females over 50 years of age seem to represent the highest risk.<sup>6, 13</sup> Symptoms disappear during sleep and can be influenced for a brief time by willpower. They may be suppressed by increasing the dose of major tranquilizers. There is no indication that any one major tranquilizer has a greater likelihood of producing the syndrome. When medication is discontinued, the symptoms may persist for several years.

### Therapeutic Approaches

As a result of the slow but unquestionable conclusion that this syndrome is not uncommon and is indeed potentially capable of dire physical, psychological, and social impairment, there has recently been much concern for therapeutic approaches. Last year, Kazamatsuri, Chien, and Cole reviewed the literature concerning therapeutic approaches.<sup>7</sup> The approaches were divided into three major categories: dopamine-depleting drugs, dopamine-blocking drugs, and other miscellaneous drugs or treatments. The dopamine-depleting drugs included reserpine, tetrabenazine, oxypertine, and alpha-methyldopa. The blocking drugs included the phenothiazines and butyro-

phenones. The third category included the monoamine oxidase inhibitors, 1-tryptophan, amantadine, pyridoxine (vitamin B<sub>6</sub>), antiparkinson drugs, minor tranquilizers, sedatives, and stereotaxic surgery. They found that a small variety of drugs have been reported to be effective in the short-term treatment of the syndrome, but "no definite effective treatment has been clearly shown to alleviate or reduce tardive dyskinesia symptomatology over a long time period." Those drugs which Kazamatsuri et al. found to hold most promise were reserpine, tetrabenazine, and thiopropazate. Peters also recently indicated optimism about the efficacy of reserpine.<sup>8</sup> Kazamatsuri et al. found in their own study, short term improvement with tetrabenazine, haloperidol, and thiopropazate.<sup>9, 10</sup> In Ayd's most recent review of the subject, he indicated that reserpine and tetrabenazine showed the greatest promise in reducing the symptoms; however, he stated; "Regrettably, all of the studies of the various drugs to treat this neurological disorder have been of short duration and in all cases the symptoms of dyskinesia returned to pretreatment levels after the suppressing drug was discontinued."<sup>11</sup>

These reviews have been consistent in their demonstration that antiparkinson or anticholinergic drugs are not therapeutic. Since these drugs are often and habitually given in combination with the major tranquilizers for the apparent purpose of prophylaxis against extrapyramidal reactions, their relevance to the tardive dyskinesia syndrome is questioned. Rubovits and Klawans recently presented evidence suggesting that anticholinergic medications may decrease the threshold for tardive dyskinesias and should worsen the condition.<sup>12</sup> They recommended that anticholinergic agents not be routinely given with the major tranquilizers.

The pathogenesis and pathophysiology of tardive dyskinesia remains a matter of conjecture.<sup>13</sup> Similar abnormal movements occur in other situations such as senile chorea and Huntington's chorea, as a side effect of *l*-dopa, and in Gilles de la Tourette's disease. In 1966 Sourkes and Poirier emphasized the roles of dopamine and serotonin in the striatum for the control of limb movement and posture.<sup>14</sup> The relevance of dopamine activity is certainly apparent by the mechanisms of action known to the more effective treatment drugs. Klawans in his article, "The Pharmacology of Tardive Dyskinesias," presents a very recent discussion of the subject.<sup>15</sup>

## Conclusion

What preventive recommendations are in order for those of us who may be using major tranquilizers? The foremost is a conscious awareness of the potential onset of the tardive dyskinesia syndrome. Then, the selection of major tranquilizers as the drug of choice should be carefully examined. Their sole use as hypnotics is questionable, and often they are used in situations where antidepressants would be more appropriate. Those patients requiring and receiving long-term therapy with the major tranquilizers should be examined at least every 2-3 months for early neurological symptoms. Also, they should intermittently be completely withdrawn from the drugs in order to unmask tardive symptoms. Whenever possible, the patient should be instructed to observe for early symptoms himself. Frequent refills on prescriptions should be avoided. The earlier the symptoms are recognized and the drugs are withdrawn, the better is the prognosis for recovery.

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## Disclosure of Medicare Records

Final regulations providing for disclosure of certain Medicare records, as published in the Federal Register on March 19, 1973, stated that disclosure of the name of a provider, physician, or other person found by a Medicare carrier or intermediary to have engaged in a pattern of furnishing excessive services or supplies will be disclosed only after consultation with a professional medical association functioning external to the administration of the Medicare program, or if appropriate, the state medical authority; however, the name of any provider, physician or other person will not be disclosed unless he has had an opportunity to submit a statement or evidence on his own behalf which will be taken into account in determining whether his name should be disclosed.



# The Migratory Disabled Veteran

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AND BERTHA MOST, M.D.

**Abstract:** This report provides descriptive and statistical information about veteran psychiatric patients who either move permanently to or winter in Florida and obtain inpatient care in the Gainesville VA hospital. The data show that these patients make up a large percentage of the psychiatric population in the hospital. As a group they tend to be rootless. Separated, divorced, or single, their family ties are frayed; recent migrants to the state, they feel no strong community allegiance; jobless, they cannot identify with work and employment. It is no wonder that they look for a home in the VA hospital system.

We predict that when National Health Insurance arrives, unless patients are assigned to doctors and facilities in their home areas, as is done in Britain, Florida can expect increasing floods of psychiatric and other patients to migrate here. Physicians and health planners should consider this eventuality.

Disabled veterans, like their healthy counterparts, often retire permanently in Florida. Others, transient "Snow Birds," merely winter in southern resort areas. The 166 VA hospitals scattered over the 50 states and Puerto Rico feel the effect of this mobility. In November, on every hospital service, surgery and medicine as well as psychiatry, certain patients in VA hospitals north of the Mason-Dixon line arrange to be discharged and travel south to the Bay Pines, Miami and Gainesville hospital areas. Increasing numbers of disabled veterans make permanent or temporary homes usually within 30-35 miles of these hospitals where they are eligible for both in- and out-

patient care. The unity of the VA system and the eligibility of veterans for care in any VA facility allow them to move around the country at will, getting help for personal and health needs through contact with VA facilities.

Findings from studies of these patients and their health care needs will be useful for planning when National Health Insurance becomes a reality and all Americans obtain low cost or free health care wherever they care to travel. This report provides descriptive information and statistics regarding migrating veteran patients on the psychiatric service at the Gainesville VA hospital.

To obtain data about the migratory and other demographic characteristics of the disabled veteran on the psychiatric ward, the records of all veterans being treated as inpatients on the psychiatric service of the Gainesville VA hospital were reviewed during the week of April 17, 1972. Information was gathered as to birthplace, length of residence in the State of Florida, age, work habits, numbers of hospitalizations, marital status and service connection for disability. Similar data, where appropriate, were obtained from all patients admitted to the psychiatric ward of the affiliated Shands Teaching Hospital of the University of Florida College of Medicine. These data were used along with data from the 1970 census for comparison purposes.

Since the data presented here provide statistical information only about admitted patients, this study cannot indicate the full extent of the "Snow Bird" phenomenon. Most transients do not require inpatient hospital care but are treated in the admitting office or outpatient service and returned to their temporary residences. Only one in eight psychiatric patients who appears in the admitting office is admitted to the hospital.

Table 1 considers the age of the veteran patients, comparing native Floridians and immigrants. The distribution of ages is bimodal with clusters around the midtwenties and 50. The means for native Floridians and immigrants are almost identical.

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From the University of Florida College of Medicine and the Gainesville VA Hospital, Gainesville.

The authors appreciate the helpful criticism of Drs. Louis Neurnberger, John Schwab, Henry Evans, George Miller and Carolyn Hirsch, as well as Mrs. Anne Watts and Mrs. Beth Ogburn and others in the Department of Psychiatry, University of Florida College of Medicine.

TABLE 1.—ANALYSIS OF V.A. HOSPITAL  
PSYCHIATRIC PATIENTS WITH RESPECT TO AGE

NATIVE FLORIDIANS	
Range 18 to 35 years	Mean is 26 years N = 20
Range 36 to 67 years	Mean is 48 years N = 13
IMMIGRANTS	
Range 18 to 35 years	Mean is 25 years N = 15
Range 36 to 67 years	Mean is 49 years N = 38

The overall mean age for the total sample (N=86) is 39 years. The distribution is bi-modal. There is clustering according to age into two groups, midtwenties and near fifty. The means for both Native Floridians and Immigrants are almost identical.

TABLE 2.—ANALYSIS OF PSYCHIATRIC PATIENTS  
WITH RESPECT TO ORIGINAL RESIDENCE AND  
LENGTH OF STAY IN FLORIDA

	V.A. Psychi- atric Wards (N=86)	Non-Veteran Shands Psychiatric Patients (N=23)
ORIGINAL HOME		
NATIVE FLORIDIANS	38%	26%
The rest of the S. E.	15%	26%
Yankees (North and Midwest)	38	39
S.W. and West	5	5
Others	3	5
Sub-Total—Immigrants to State	62%	75%

The Immigration Growth rate  
for the State of Florida for  
the Census period 1960-70 . . . 19.5%

Patients who migrated to the

State within the last ten years 44% 26%

The underlined figures show that the percentage of immigrants in the psychiatric patient population is considerably greater than those for the State as a whole in the last ten years.

A slightly higher proportion of the non-veteran (Shands) patients are immigrants. However the majority have been in the state longer; they are a much younger age group and most have been here since childhood.

### Results

Table 2, compiled from the psychiatric in-patient populations at the Gainesville VA hospital and the Shands Teaching Hospital, compares the two patient populations with respect to the area of their original residence (birthplace) and length of residence in Florida. We have drawn attention to interesting figures by underlining. These indicate that the percentage of immigrants in both psychiatric patient populations is considerably greater than for the state as a whole in the last ten years, with the veteran population of psychiatric patients containing the largest percentage of new (less than ten year) residents. The subtotal of immigrants to the state shows that a higher proportion of Shands patients have been in the state longer. They are a much younger age group, and most have been here since childhood.

Table 3 looks at the percentage of VA service

connected disability in relation to area of original residence and length of residence in Florida. The underlined figures are again significant. The proportion of native Floridians who have a service connected disability is small (9%) in comparison with the figure for immigrants into the state (49%).

The overwhelming impression gained from Table 4 is that the psychiatric patients in the VA hospital are generally isolated or alienated from family, jobs, and communities to a much greater extent than the general population.

Table 5 is an amplification of Table 4 taking age into account. Predictably, it shows that the two younger groups of immigrants (18 to 29 years and 30 to 44 years) are more likely to be unattached while the older age groups, native and immigrants, have had more previous VA hospitalizations. Immigrants of all ages are less likely to be unemployed, possibly because newcomers to an area would have to rely more on their own financial resources than natives who could get help from family and friends.

An interesting trend appears in Table 6 which compares native Floridian patients with immigrant ones based on their length of service. Of veteran patients who had remained in service for six years or longer, 86% were immigrants as compared to 14% of natives. These findings, which are statistically significant ( $X^2 = 5.24$ ,  $p < .025$ ), tend to suggest that length of military service is related to migratory tendency and amount of dependence on the VA.

### Discussion

The increasing complexity of society is bringing about a breakdown of the family, church, and community. Without these supports many marginally adjusted people become emotionally disabled. Large, centralized organizations, of which the VA is an example, are becoming substitutes for these traditional family and neighborhood institutions.<sup>1</sup>

Today's veterans, moreover, are subject to a totally new type of pressure which does not affect other groups of the emotionally disturbed to the same degree, namely, that they have ties to the military which is now out of favor with a large segment of the American public. Unlike veterans in the immediate post-World War II period, today's ex-military person is not considered a hero. On the contrary, many Vietnam returnees in particular feel cut off from their former friends. This social attitude, which is concentrated



TABLE 3.—ANALYSIS OF V.A. HOSPITAL  
PSYCHIATRIC PATIENTS WITH RESPECT TO  
SERVICE CONNECTION; FOR DISABILITY, ORIGINAL  
RESIDENCE, AND LENGTH OF STAY IN FLORIDA

	Per Cent	N
Per cent of total psychiatric patients who are service-connected for a psychiatric disability	34%	(86)
Per cent of total psychiatric patients who are service-connected for any kind of disability	48%	(86)
	Per Cent S-C for Psy	
ORIGINAL HOME		
Native Floridians	9%	(33)
The rest of the S.E.	54%	(13)
Yankees (North and Midwest)	45%	(33)
S.W. and West	25%	( 4)
Others	100%	( 3)
SUB TOTAL Immigrants to the State	49%	(53)
	Per Cent S-C for Psy	
Length of Residence in Florida		
Under 1 year	38%	(13)
1-3 years	62%	(13)
Over 3 years	28%	(60)
SNOW BIRDS		
Yankees with under 1 year residence in Florida	42%	(12)

The striking figures relate to the percentage of patients who are service-connected for a psychiatric disability. The percentage for Native Floridians is very low, that for Immigrants comparatively high.

TABLE 4.—ANALYSIS OF V.A. HOSPITAL  
PSYCHIATRIC PATIENTS WITH RESPECT TO  
RESIDENCE IN FLORIDA, MARITAL STATUS,  
EMPLOYMENT STATUS, AND NUMBER OF  
PREVIOUS HOSPITALIZATIONS

	N=33	N	Per Cent
Native Floridian Patients			
		UNATTACHED	61
		UNEMPLOYED	70
		PREVIOUS HOSP.	67
All Immigrant Patients	N=53		
		UNATTACHED	64
		UNEMPLOYED	60
		PREVIOUS HOSP.	77
General Population Statistics			
United States 1968		UNATTACHED	29%
Florida 1970		UNEMPLOYED	2.96%
Gainesville, Florida 1970		UNEMPLOYED	2.03%

UNATTACHED includes single, separated, divorced and widowed. Patients in the PREVIOUS HOSPITALIZATION category have had at least one previous V.A. hospitalization. The psychiatric patients, Immigrant and Native, are generally isolated and alienated from family, jobs, and communities to a much greater extent than the general population.

strongly in academic communities such as that in Gainesville, contributes to the alienation and social isolation many veteran psychiatric patients feel.<sup>2-4</sup>

#### THE PERIPATETIC PATIENT IN THE ADMITTING OFFICE

The typical migratory psychiatric patient appears in the VA hospital admitting office in the late afternoon or early evening. He has a better chance of gaining admission then when the regular cadre of professional staff is off duty, and when inexperienced resident physicians are covering the admitting office. When these patients need hospitalization a bed may not be available.

If offered immediate admission to a hospital in a neighboring state—Georgia or Alabama—they characteristically turn it down, preferring to go on the waiting list to enter a Florida facility.

Migrating veterans, both of the transient and permanent variety, include both middle aged World War II veterans and the younger Vietnam groups. They usually have either severed all ties with their families or make only an occasional telephone call to mother or sister. Frequently, they list no one on the VA form as next of kin. Very commonly they are bachelors who have lived with mother until she died; then they traveled to Florida and came to the VA hospital.

TABLE 5.—ANALYSIS OF VETERAN PSYCHIATRIC PATIENTS BY AGE AS WELL AS BY UNATTACHMENT, UNEMPLOYMENT, PREVIOUS HOSPITALIZATION, AND BY IMMIGRATION PATTERN

	UNATTACHED		UNEMPLOYED		PREVIOUS HOSP.	
Age 18-29 Years						
Native Floridians N=16	N=10	63%	N=11	69%	N=9	56%
Immigrants N=13	N=11	85%	N=7	54%	N=7	54%
Total N=29	N=21	72%	N=18	62%	N=16	55%
Age 30-40 Years						
Native Floridians N=8	N=5	63%	N=5	63%	N=5	63%
Immigrants N=10	N=9	90%	N=6	60%	N=8	80%
Total N=18	N=14	78%	N=11	61%	N=13	72%
Age 45 + Years						
Native Floridians N=9	N=5	56%	N=7	78%	N=8	89%
Immigrants N=30	N=14	47%	N=19	63%	N=26	87%
Total N=39	N=19	49%	N=26	67%	N=34	87%

This is an amplification of Table 3 taking the Age Factor into account. It shows, as might have been conjectured, that the two younger groups of Immigrants are more likely to be unattached, while the older age groups (both Native and Immigrant) have had more hospitalizations.

TABLE 6.—COMPARISON OF NATIVE FLORIDIAN AND IMMIGRANT PSYCHIATRIC PATIENTS BY LENGTH OF SERVICE

Service	N.	Native Floridians	Immigrants
Under 2 years	37	40½%	59½%
3-5 years	34	47%	53%
Over 6 years	14	14%	86%
Total Percentages		38%	62%

A larger percentage of patients who had served in the Armed Forces for 6 years or longer tended to be migratory.

Displaced veteran psychiatric patients often carry cards which indicate that they previously were active members of veterans' organizations—Veterans of Foreign Wars and American Legion. Many keep these cards even though they are out of date.

#### THE MIGRATING PATIENT IN THE HOSPITAL

The psychiatric diagnoses of the migrating veterans range from anxiety reaction to chronic schizophrenia. Most of the time they are receiving minimal amounts of phenothiazines.

Typically, within one or two days after their admission to the hospital, the patients' conditions change. When seen in the admitting office they usually appear to be depressed and beaten down. One or two days later the depression is gone and they look bright and happy.

During their stay in hospital, they usually ally themselves with the doctors, nurses, and other figures that they feel are important and in power. The doctor usually likes to have these patients in group therapy because they support him and always seem to say the right thing. They praise the hospital and attendants and are ready to jump at

other patients who criticize the staff or hospital in any group session.

Wandering from place to place and from hospital to hospital is really the life style of these patients. Most of them do not lack intelligence or other abilities that would help them succeed in the outside world. They seem to have a basic inability to socialize and remain part of a community outside the VA system. Most are also incapable of remaining a part of a family unit. Usually, if they have ever been married, they are now divorced.

As increasing numbers of disabled, unstable immigrants enter a community, they begin to overtax community health agencies and other helping institutions. Already over 7% of 6.8 million Florida residents receive social security because they are disabled or are members of a family of someone who is disabled or retired. In addition, retired persons in Florida number over one out of ten residents, the highest ratio of any state. As our state continues to grow from immigration, we can expect to have to face here the issue of managing the needs of ever-greater numbers of the emotionally unstable and physically disabled.

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# The Mercury Hazard of Pier and Surf Caught Fish

MATTHEW MERLISS

**Abstract:** Families living near the ocean sometimes supplement their diet with pier or surf caught fish. In this study the hazard of methyl mercury ingestion from consumption of such fish was evaluated. Of fifty-two specimens of small to medium sized edible fish caught from popular fishing piers and beaches, several of which were close to sewage and industrial effluent, all specimens demonstrated less than 0.5 ppm of mercury, the working standard set by the FDA. 0.1 mgm methyl mercury consumption a day is probably entirely safe. It would take the consumption of about 826 grams of cleaned flesh of such fish each day to reach this level. It would be physically impossible to catch or eat enough fish to reach the toxic level of 1.0 mgm methyl mercury daily.

In 1953 an apparently previously unidentified neurologic disease appeared about Minimata Bay in Japan. It affected 111 persons and caused 44 recorded deaths.<sup>1</sup> It was at first thought to be an odd form of encephalitis. Later it was noted that the disorder occurred primarily in those families who relied on the freely taken fish of the bay to supplement their diet. It took about five years of search all told before methyl mercury was identified as the toxic compound in fish and shellfish that was causing this illness. Banning such fishing stopped new cases. Ultimately the mercury was traced to the effluent from a plastics plant. In 1965 at Niigata, Japan, similar symptoms were noted in 120 persons, and the disorder traced again to methyl mercury contamination of fish, the mercury discharged into the Agano River by another plastics plant.<sup>2</sup> At that time fish taken from lakes and coastal waters of Sweden similarly showed a worrisomely high level of mercury.<sup>3</sup> On this continent in 1969 a graduate student acquainted with the Scandinavian experience, Norvald Fimraite, submitted 42 samples of fish from Lake St. Clair for analysis and found that many samples exceeded the action guideline limit of 0.5 ppm of mercury just previously set

by the FDA.<sup>4</sup> Numerous studies since then have shown mercury content of fish taken from various United States fisheries at or above the action guideline, the most heavily contaminated being swordfish and tuna.<sup>3,4</sup>

In southern California between the Mexican border and Ventura, millions of people live within walking or ready driving distance of the coast. There are a number of fishing piers on this coast. Moreover hook and line fishermen are frequently seen all along the coast at rocks and inlets, and often directly fishing in the open surf.

Many of these fishermen are observed to be older men and retired. The same faces may be seen repeatedly at the same fishing spots and a little questioning reveals that some of the fishermen are providing additional food for the family table as often as two or three times a week. Usually with patience and a modest amount of skill the fisherman can often manage a fair sized catch in an average day. Such fishermen with restricted incomes and unrestricted leisure are frequently seen surf and pier-fishing along the Florida coast as well as the coasts of Oregon and Washington.

Some fishing piers, such as one in South Laguna, are close to sewage effluent. Others are in areas not far from industrial installations. The problem then arises as to whether a reasonably successful fisherman in this area, bringing home his catch two or three times a week, is hazarding his family's health by introducing methyl mercury into their diet.

## Procedure

Fifty-two fish were caught at fishing piers at Ventura, Port Hueneme, Santa Monica, South Laguna, Oceanside, and San Diego. No fish larger than 20 inches was taken. Small fish, not likely to be eaten were thrown back. The fish were identified and then preserved by prompt freezing. A portion of the flesh from just above the tail, the area being approximately the same in all specimens, was then tested for mercury at Bioscience Laboratory in Van Nuys. The testing method was based on the flameless atomic absorption technique for sub-milligram quantities of mercury.<sup>5</sup>

Mr. Merliss is an undergraduate student at the University of California in San Diego.

## Results

Common Name	Mercury content microgram per gram wet weight
Ventura	
1. Queenfish	0.02
2. Queenfish	0.04
Mean:	.030 ugs/gm.
Port Hueneme	
3. Sculpin	0.03
4. Sculpin	0.03
5. Sculpin	0.03
6. Sculpin	0.04
7. English Sole	0.05
8. Calico Surfperch	0.06
9. Sculpin	0.07
10. Sculpin	0.07
11. Sculpin	0.07
12. Sculpin	0.09
13. Sculpin	0.09
14. Sculpin	0.24
15. Silver Surfperch	0.11
SD:	.054 ugs/gm.
Mean:	.075 ugs/gm.
Santa Monica	
16. Queenfish	0.11
17. Sculpin	0.20
Mean:	.115 ugs/gm.
South Laguna	
18. Silver Surfperch	0.02
19. Silver Surfperch	0.04
20. Calico Surfperch	0.04
21. Calico Surfperch	0.17
22. Black Perch	0.17
23. Black Perch	0.28
24. Queenfish	0.20
25. Queenfish	0.21
26. Pile Perch	0.05
27. Corbina	0.23
Mean:	.141 ugs/gm.
Oceanside	
28. Kelp Bass	0.05
29. Kelp Bass	0.06
30. Kelp Bass	0.07
31. Kelp Bass	0.07
32. Kelp Bass	0.09
33. Kelp Bass	0.12
34. Kelp Bass	0.15
35. Kelp Bass	0.22
36. Kelp Bass	0.07
37. Top Smelt	0.07
38. Top Smelt	0.07
39. Top Smelt	0.09
40. Top Smelt	0.44
Mean:	.121 ugs/gm.
San Diego	
41. Kelp Bass	0.03
42. Kelp Bass	0.05
43. Kelp Bass	0.07
44. Kelp Bass	0.07
45. Kelp Bass	0.09
46. Kelp Bass	0.24
47. Kelp Bass	0.27
48. Kelp Bass	0.36
49. Queenfish	0.08
50. Queenfish	0.21
51. Queenfish	0.30
52. Top Smelt	0.13
SD:	.106 ugs/gm.
Mean:	.159 ugs/gm.
Composite mean:	
.1208 ugs/gm.	
Composite standard deviation:	
.0960 ugs/gm.	

## Discussion

These were small to moderate sized fish, likely to be readily caught and eaten by pier and surf fishermen. All tested well below the 0.5 ppm mercury set up as a guideline by the FDA. Current investigation suggests that the human being will tolerate safely 100 micrograms of methyl mercury orally a day but that neurologic injury will result from ingestion of one milligram per day.<sup>6</sup> This then suggests that it is safe to eat up to 826 grams of cleaned flesh of surf or pier caught southern California fish a day or about 12.9 pounds a week. Even the most dedicated and tenacious fisherman would be not likely to take that much regularly on a daily basis from these waters by hook and line. No fisherman could catch or eat enough fish to reach the toxic level of one milligram of methyl mercury a day. This would require the consumption of about 129 pounds of cleaned fish flesh a week per person.

Since the size of a fish appear to be a major determining factor in whether it bears a high burden of mercury it is likely these results, obtained in southern California, are translatable to the Florida, Oregon, Washington and other coasts where small fish, taken by pier and surf fishing, are used as a means of implementing the family food supply.

## Conclusion

The mean mercury concentration of 52 hook and line caught fish from piers and surf was 0.1208 ugs/gm. This level is low enough that no realistic danger from methyl mercury intoxication exists even to those fishermen who fish from the piers and surf regularly and often and use the fish to supplement their family diet.

The author wishes to acknowledge his gratitude to Dr. Norman Weissman of Bioscience for his valued suggestions.

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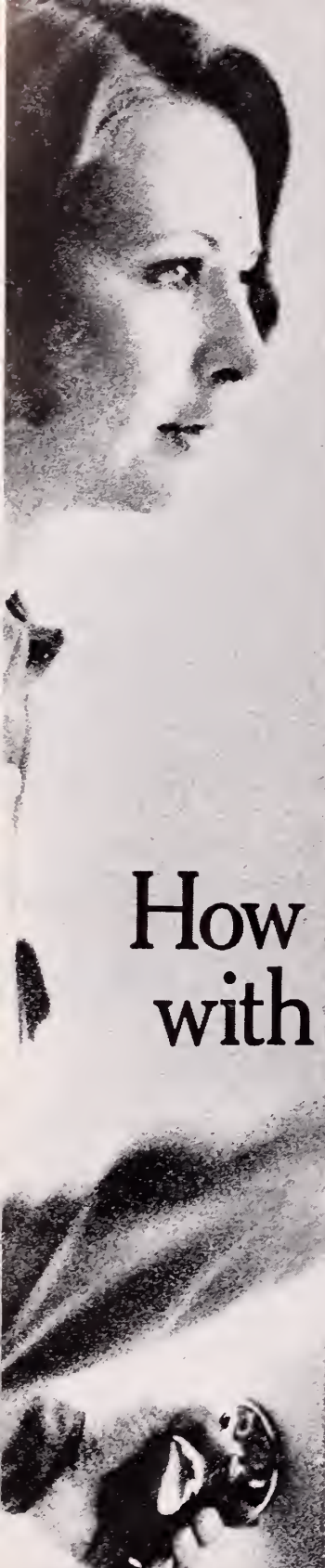
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#### **Total therapy: 14 days**

Some recent studies suggest that therapy in acute nonobstructed urinary tract infections should be continued for 10 to 14 days even

if patients become asymptomatic in 2 or 3 days, as they often do.<sup>1,2</sup> After inadequate treatment, of course, survival of bacteria can cause a quick recurrence of infection.

The problem of persuading a patient to complete the full course of therapy remains difficult. Perhaps agreeing on the date for a follow-up examination at the end of medication may be the most effective way of convincing a less than enthusiastic patient to continue therapy even after she becomes asymptomatic.

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tions. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

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**Warnings:** Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dys-

crasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.



reached in 2 to 3 hours and can be maintained on the recommended 4 to 8 Gm/day dosage schedule that's convenient for almost all patients.

#### Generally good tolerance

Gantrisin (sulfisoxazole) Roche causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Gantrisin may usually be given safely, even for prolonged periods, in the treatment of chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms.

(See Important Note in summary of product information.)

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#### Economy

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Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have

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# Wisconsin Investigates Chiropractors

JOHN R. FEEGEL, M.D., J.D.

The Governor of Wisconsin appointed a "Health Planning and Policy Task Force" which received, on October 23, 1972, a comprehensive report from its Chiropractic Study Committee. The Task Force accepted as a basic premise that "... every citizen of Wisconsin has the right to quality health care." The committee recognized the right of each individual to control his own body, and that the state has an obligation to provide the citizen with information on which he may make a rational decision. Since it was noted that many citizens seek chiropractic services despite "... the fact that overwhelming evidence exists to demonstrate that chiropractic theory and practice have no scientific validity, and have the potential for doing substantial physical harm," the committee undertook to study chiropractic in depth. It was the committee's intention to submit the findings of the study to the state for legislative and insurance purposes.

### Study and Investigation

The committee met with representatives of the Wisconsin Chiropractic Association, Basic Sciences Examining Board, Wisconsin Board of Examiners in Chiropractic, Ad Hoc Committee on Chiropractic of the State Medical Society, and Wisconsin Association of Osteopathic Physicians and Surgeons. Each group submitted materials and views for consideration.

Eight public hearings were held throughout Wisconsin and the minutes were reviewed for matters of chiropractic interest, with appropriate follow-up inquiries made.

The committee visited the Palmer College of Chiropractic in Davenport, Iowa, and read a large amount of authorized chiropractic literature. An

intensive questionnaire was submitted to practicing Wisconsin chiropractors with the cooperation of their own state association. Two-hundred fifty-six responses to this questionnaire were received. In addition, 4,392 medical doctors and 140 osteopathic physicians were also surveyed by questionnaires.

The committee reported that chiropractic was devised in 1895 by Daniel David Palmer, an Iowa grocer, who described himself as a magnetic healer. Central to the theory of chiropractic is the concept of "vertebral subluxation." This may be simply defined as an incomplete or partial dislocation of the vertebra, causing a narrowing of the opening through which spinal nerves pass, causing, in turn, irritation of the nerves. Citing an official publication of the American Chiropractic Association, the committee noted that the treatment seeks to "... restore the mobility of the joints or to allow the vertebra to assume its normal position of rest."

Differences in approach to this theory exist among practicing chiropractors. The International Chiropractors Association (ICA) apparently represents the more restrictive approach and limits the treatments to spinal adjustment. This group, commonly called "the straights," represents approximately 4,000 members and is closely associated with the Palmer school in Davenport. The American Chiropractic Association (ACA), numbering about 7,300 members and commonly referred to as "the mixers," has departed from strict interpretation and includes dietary, nutritional supplementation, and physiotherapy in methodology.

Within the limitation of available time, the Wisconsin Committee studied chiropractic literature, including the observations of other bona fide studies of the subject. Some of these other studies

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included the HEW report to Congress (1969), a Royal Commission report on Chiropractors, Osteopaths and Naturopaths in Canada (1965), the Stanford Research Institute's Study, "Chiropractic in California," (1960), and the report of the National Advisory Commission on Health Manpower (U.S. GPO 1967).

The HEW study was quoted as stating that "chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education does not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

The committee quoted the National Advisory Commission on Health Manpower in part that "medical authorities unanimously agree that chiropractic has no validity," and that "the cult's theories have never been supported by objective evidence, and they have been thoroughly refuted by medical science."

The Canadian research team was quoted as being supportive of the value of selected manipulative treatments but that chiropractors were so deficient in their training differential diagnosis that they were not qualified to determine when to apply the manipulations.

The Wisconsin Committee noted that neither the U.S. Public Health Service (NIH) nor the National Research Council of Canada had made research grants to chiropractic institutions. The

HEW's report had justified this failure to fund research on lack of funds and on the lack of qualifications of the chiropractic school staffs. The eight chiropractic schools approved by Wisconsin were invited to submit evidence of a scientific basis for chiropractic and to report on their research efforts. Only one school replied, submitting a research proposal entitled "Reflex Vasomotor Relationships Between Thoracic Sympathetics and the Middle Ear."

The chiropractors claimed to be able to diagnose and treat a wide range of illnesses according to a 1963 survey by the American Chiropractic Association. The table of these available treatments as quoted by the Wisconsin Committee is reproduced.

One chiropractor "asserted flatly" to the committee that he could cure epilepsy. When asked why he had not published so that more people could benefit from the cure he replied that he had been too busy to organize his research and publish his findings.

The committee noted, however, that chiropractors were not totally unrecognized. As examples, they stated that chiropractic students are supported under the G.I. Bill of Rights, in some states chiropractors are reimbursed under Medicaid, the IRS allows deductions for chiropractic fees, the U.S. Immigration Service considers chiropractors outside its quotas, chiropractors qualify under Workmen's Compensation programs in several states (including Wisconsin), several insurance companies recognize chiropractic for payment, and that an inclusion of chiropractors in Medicare benefits was submitted to Congress in

PERCENT OF CHIROPRACTORS REPORTING TREATMENT OF SPECIFIED CONDITIONS: 1963

Condition	Percent	Condition	Percent
Headache	98	Impaired hearing	59
Sinusitis	94	Hemorrhoids	58
Constipation	94	Goiter	48
High blood pressure	93	Polio	47
Common cold	92	Diabetes mellitus	46
Asthma	89	Impaired vision	44
Bronchitis	86	Chorea	42
Low blood pressure	86	Rheumatic fever	37
Hay fever	83	Hepatitis	32
Gall bladder	82	Pneumonia	32
Colitis	80	Mumps	31
Diarrhea	79	Acute heart	31
Ulcers	76	Appendicitis	30
Deficiency anemia	73	Pernicious anemia	24
Chronic heart	70	Cerebral Hemorrhage	18
Genitourinary	66	Lacerations	12
Mental, emotional	68	Fractures	9
Tonsillitis	67	Leukemia	8
Dermatitis	67	Cancer	7
Hives	60	Diphtheria	4

October 1972 despite HEW opposition. The committee noted, however, that the U.S. Office of Education and the National Commission on Accrediting does not list any chiropractic school as accredited, that chiropractic students are not given special deferment under Selective Service, and that the U.S. Armed Forces do not give chiropractors any special rank.

### Education and Licensure

Turning its attention to chiropractic education, the committee examined and visited the Palmer College. The committee concluded that the faculty-student ratio was inadequate (27 faculty members for 1,300 students); that basic sciences are taught by persons who lack adequate training. The highest nonchiropractic degrees at Palmer were an M.S. and an M.A., both held by persons in administrative positions. The committee found the Palmer library inadequate, small, and not up to date. The method of instruction at Palmer was noted to be programmed and by rote. No independent research was encouraged. Many students were able to hold concurrent, full-time jobs elsewhere. The requirements for admission to Palmer were considered to be substandard. Palmer reported it was changing its admission requirements from high school graduates to two years of college, but historically, few were ever denied admission. No laboratories were pointed out to the visiting committee members, but two "obviously antiquated" x-ray machines were viewed. The financial structure of Palmer was found to be "obscure" with "close and complex" ties to the Palmer family interests.

The committee also reviewed the licensure requirements for chiropractors, noting that while all states except Louisiana and Mississippi have licensure requirements, only Louisiana demands that chiropractors comply with its medical practice act, requiring among other things, a diploma from an approved medical school. The Louisiana approach has been upheld in federal court. According to the committee, the effect of "licensure" has, in some areas, cast an aura of legitimacy on chiropractic rather than setting high, protective standards. The committee described such licensure as a "boomerang effect." While Wisconsin requires its chiropractic applicants to sit the same basic science exam as other medical practitioners, the vast majority of chiropractic applicants circumvent the exam by applying for reciprocity.

The Florida license to practice chiropractic is accepted in Wisconsin despite the fact that there is no Florida chiropractic college.

The 1960 U.S. census reported that there were 14,360 chiropractors and the Wisconsin Committee estimated that there were 15,000 to 17,000 chiropractors in active practice in 1968. As many as 3,000,000 persons may be treated annually by chiropractors. The committee reports that about 80% of Wisconsin chiropractors were in solo practice and that 60% of the practitioners were located in communities of under 50,000 people. Wisconsin had 8.9 chiropractors per 100,000 population in July 1971. Of the reporting chiropractors, 91% used x-ray. The committee recommended that additional studies be made to assess the adequacy of chiropractic x-ray training.

The committee found that the health hazard of chiropractic to the public to be three fold. First, the chiropractic treatment frequently delays effective medical care until too late; second, the treatment often aggravates existing conditions; and third, it sometimes produces actual physical damage to patients. In part, the success of chiropractic may be due to the abandonment of the nonpathological patient by the too busy medical profession. In the treatment of emotional disorders responsive to an "attentive ear" coupled with the chiropractor's "laying on of hands," the committee found that chiropractic was filling a social need now partly ignored by bona fide medicine.

### Conclusion

In conclusion, the Wisconsin Committee recommended to the Governor's Health Planning and Policy Task Force,

... that programs for education of the public on the nature of chiropractic be implemented, demonstrating its "lack of scientific validity and potential hazards associated with its use."

... that legislation including chiropractic under insurance coverage be opposed.

... that no public resources be permitted to further use of chiropractic.

... that coverage under the Wisconsin Workmen's Compensation law be removed.

... and that the Basic Science Examining Board be directed to re-examining regularly the standards for those seeking licensure by reciprocity.

► Dr. Feegel, 217 Cook Street, Brandon 33511.



should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005





## Editorials

### Whose Rights?

The American Civil Liberties Union has enunciated the principle that the individual is the sole owner of his body, that he has the "right" to use it as he desires, and that this "right" includes the use of drugs; and that society has no right to limit or proscribe what he may do with his body. As a matter of practicalities, society knows that drug users become addicts, addicts become pushers to support their disease, and that pushers make more addicts who participate in and raise the rate of crimes against society. Since recorded history, society has quarantined and segregated its members with contagious diseases and antisocial behavior. Nearly all societies draft or induct the physical bodies of their young men for the defense of that particular society, no matter what the type of government. Has society no rights over the individual person? A recently published study by something called the National Advisory Commission on Criminal Justice, Standards and Goals has stated that incarceration is a "miserable failure" in combating crime. It urges a reduction in the nation's prison system, reduction and/or elimination of prison sentences for crime, and immediate parole for nearly all prisoners. The Commission, set up by the government, rejects the ideas of prison as punishment or as protection for society by quarantine of the offender, and proposes the idea of rehabilitation as the only reward or consequence of crime or antisocial behavior.

Somehow, these groups seem to have lost their way and missed the point. John Donne has written that no man is an island unto himself, but is a part, for good or bad, of the society in which

he exists. A government is only a part of any society, and societies throughout history have used their governments to protect society from the unbridled actions of the individual. Today we seem to have lost sight of that function of government, and to be concerned only with rights of the individual and the rights of small groups of minorities. Our laws and our constitution prescribe prison as the *punishment* for crimes, not rehabilitation; and I do not believe that our society is yet ready or desires to do away with punishment for antisocial behavior or crime.

So today, who protects the rights of society? The courts are part of our government and yet they set themselves apart philosophically from the rest of government. They apparently see that they have a duty only to protect the rights of the individual and no canon to protect the rights of society. Who protects my rights, the rights of the great mass of society who do not participate in crime and antisocial behavior, but only suffer from it? Who protects the right of society to be free from internal turmoil and external subversion? I don't know who protects society's rights, but I believe that our courts, as part of our government, should give strictly equal concern to the rights of society as well as the rights of the individual. Perhaps when society's rights get an equal concern from our system of law and courts then the confidence of our people in our system of law and its courts will be restored.

JAMES H. CORWIN, M.D.

► 3599 University Boulevard, S., Jacksonville 32216.



## The Name of the Game is Money

In almost every discussion of PSRO that I have heard or read, the proponent has seemed to emphasize the "educational" value of the program. Each becomes ecstatic about how much the private practitioner will soon learn—thanks to this legislation. They wax enthusiastic in their descriptions how the quality of care will improve once the program gets rolling! They do this, despite the great difficulty being experienced just devising a system to evaluate the present quality of care.<sup>1</sup>

In contrast to this, they are almost struck mute regarding the main reason the PSROs were instituted. Stripped of all the high flying verbiage, the Bennett Amendment was passed to reduce the costs of medical care to the government. What puzzles me is the minimal reference to the financial aspects of this program; perhaps they think it is crass to mention MONEY. It seems more likely, however, that this is another attempt by the government to sugar coat the unpleasant reality of the situation.

There are going to be reductions in federal expenditures for medical care; the present admin-

istration has made that clear. It has attempted to reduce various health programs. It has proposed legislation requiring larger contributions by Medicare recipients for their hospital costs, and so, they accentuate the positive ("education") but fail to eliminate the negative (the money crunch)—to paraphrase the lyrics of Johnnie Mercer's song.

In an interview in the American Medical News,<sup>2</sup> Warren I. Bauer, M.D., the head of the PSRO program is quoted as saying: "The government is paying for a significant amount of medical care. It wants to see that the care being received is appropriate." An old proverb puts it more succinctly—He who pays the piper calls the tune. Once again we are learning the truths that reside in old platitudes.

### References

1. Brook, R. H. and Appel, F.A.: Quality-of-Care Assessment: Choosing a Method for Peer Review, New England J.M. 288:1323-1329, 1973.
2. Bauer, W.I.: American Medical News, pg. 7, June 25, 1973.

R.T.D.

## Computers Still Not Making it as Clinicians

A one-day workshop on computerized data in clinical medicine held in New York City under joint sponsorship of the Department of HEW, WHO and AHA outlined the revolution of certain aspects of medical care by the computer. Such things as hospital record keeping, administrative functions and the scheduling of admissions, diagnostic tests and operations, were disclosed as producing more effective internal communication, increasing real nursing time, a saving of patients' time and improved monitoring of activities (both inpatient and outpatient). Through its contribution to the efficiency of hospital administration, the computer was alleged to reduce the cost of medical care but its impact on the quality of care was questioned by some who had seen the computer go astray in areas of medicine calling for critical judgment and discrimination.

At the meeting, skeptical physicians were criticized as being unwilling to formulate data or questions in a form that the computer could

handle, that the problem is exactly like that found in taking any medical history, so questions must be carefully designed, short, straight and to the point.

To the contrary, face to face nondirective patient-physician interview encouraging a spontaneous flow of information is the basic tool of clinical medicine and a successful interview yields far more riches for the patient and physician than mere information. The patient wants to know what's wrong. Is it serious? Will it affect my ability to care for my family? What will it cost to cure me? The relationship built during the patient's first interview is the foundation for trust and respect which in turn is the basis for therapy, and provides essential ingredients for the fulfillment of a lifetime of medical care.

Any conscientious, understanding practicing family physician could have told the workshop that!

C.M.C.

# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopen malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions ●



## INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

# Chewable Tablets<sup>500 mg</sup> Mintezol® (THIABENDAZOLE | MSD)



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include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.  
**Supplied:** Chewable tablets, containing 500 mg thiabendazole, in boxes of 36, strip packaged, individually foil wrapped; Suspension, containing 500 mg thiabendazole per 5 ml, in bottles of 120 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486



## Letters

Dear Editor:

RE: Paramedical personnel performing insurance and employment examinations and measurements.

The Board of Medical Examiners has definitely ruled that the performance of certain measurements and other examinations for insurance companies and other companies in evaluating a person for an insurance policy or for employment constitutes the practice of medicine. *Therefore, such an operation must be under the direct supervision and responsibility of a licensed physician.* This means that this operation must be within the physician's office the same as his practice activities. It cannot be set up in a separate building and be theoretically supervised by a physician who practices elsewhere. This, in the opinion of the Board, does not constitute responsible supervision of this activity.

Apparently many companies and other organizations are setting up such activities without consulting this Board or without the permission of this Board. Several have appeared before the Board requesting the Board's permission and have been denied this request because of inadequate supervision by a licensed physician. The Board wishes to make it *quite clear that such activities are illegal and constitute the practice of medicine in violation of the Medical Practice Act unless there is proper supervision by a licensed M.D.* Again this means that the activity must be within the physician's office and under his direct supervision. If it is elsewhere, he must be present when the activity occurs. To do otherwise is in violation of the Medical Practice Act and any physician who lends his name to such an operation as medical director is aiding and abetting the illegal practice of medicine.

The Board urges that the Florida Medical Association inform its membership of this decision by the Board regarding insurance and employment examinations and measurements by allied health personnel and that physicians throughout the state condemn this activity and report such to the Board unless it fulfills the above requirements

of the Board with adequate licensed M.D. supervision and responsibility. If licensed physicians do not see that there is adequate control and responsibility of such activities, this could well get out of hand and be the forerunner of many other medical activities which traditionally are performed by the licensed M.D.

The Board also requests that all insurance companies operating in and selling policies in Florida not use such facilities unless these facilities are in compliance with the laws regarding the practice of medicine in our State.

GEORGE S. PALMER, M.D.

EXECUTIVE DIRECTOR

BOARD OF MEDICAL EXAMINERS

TALLAHASSEE

Dear Editor:

We have had a number of comments from physicians over the past months concerning the wording on Medicare's explanation of benefits notices explaining reductions in charges. Many physicians felt that the use of such terms as "reasonable charge" or "allowed charge" intimated that there had been an overcharge or an unreasonable charge. While it was not the program's intent or desire to cause such misunderstandings, I know that such was the case in a number of instances.

I am happy to be able to tell you that the Bureau has recently revised the format of the explanation of Medicare benefits and I feel certain that the new approach will eliminate the possibility of confusion in this area. Carriers have been instructed to modify their systems to enable them to use the new EOMB with their next printing of the form.

Basically, the form has been extensively rewritten and reorganized to help the beneficiary better understand how the benefit was computed. The columns have been numbered and several



of the captions have been revised for clarity. Explanatory statements have been expanded to furnish approved language for a greater variety of services and circumstances. The front of the form will contain, among other items, the following captions:

1. Services Were Provided By
2. When
3. Amount Billed
4. Amount Approved
5. Explanation of any Difference Between Columns 3 & 4, Medicare Does Not Pay For:

When the "Amount Billed" and the "Amount Approved" amounts differ, a reference will be made to explanatory paragraphs on the back of the explanation of Medicare benefits form. These explanatory paragraphs are as follows:

#### 4. HOW MUCH DOES MEDICARE PAY

Medicare pays 80% of the charges in Column 4 above the annual deductible. The annual deductible is now \$60. For calendar years before 1973 it was \$50.

Medicare pays 100% of the charges in Column 4 for radiology and pathology services from a physician while you are a bed patient in a qualified hospital.

Medicare also pays 100% of the charges in Column 4 for laboratory services if the laboratory has agreed to accept a negotiated rate as payment in full.

#### 5. IF PAYMENT NOT BASED ON THE FULL AMOUNT BILLED

The amount Medicare may pay under law is limited to the lowest of:

- a. Customary charge, i.e., the charge made by the physician or supplier in 50% of his billings during the base year.
- b. Prevailing charge, i.e., the charge made 75% of the time by other physicians or suppliers for similar services in the area during the base year.
- c. The amount permitted under the limits established by the Cost of Living Council.

Hopefully, the revision will eliminate the potential for misunderstandings experienced in the past.

JAMES R. WILLIS, PROGRAM OFFICER  
DISTRICT OFFICE AND PROFESSIONAL GROUPS  
DEPARTMENT HEW  
ATLANTA, GEORGIA

Editor's Note: The following letter from Dr. Nickolaus is in response to Dr. Von Thron's plea, immediately after his installation, for letters from members of the Florida Medical Association addressed to 'Dear They' with suggestions as to how the Association might better serve all or with questions about the activities of the Association. As far as is known, this is the only such letter that has yet arrived addressed to the 'they,' everyone says runs the Florida Medical Association.

The points that Dr. Nickolaus makes are all good ones and the Executive Committee, at its last meeting, dealt with several of them. An attempt is being made to get the Blue Shield meeting held at a time when better participation can be achieved. The Executive Committee authorized a meeting in September in Orlando for present Presidents-Elect and Executive Directors of the county societies to meet with the FMA Executive Committee to discuss problems they wished to bring before them.

If you have a gripe, a suggestion or a recommendation, put it in a letter entitled 'Dear They' and send it to *The Journal*. We'll see that it's published.

Dear They:

What can FMA do for me? Joe, I believe the FMA is doing a good job; it is providing leadership for medicine in the State of Florida and also has been a great influence on a national level. The FMA has been a leader as far as peer review is concerned, and I hope we will continue to be as highly thought of as far as PSRO development.

I had written the question, "FMA and what it can do for me;" I feel this is turned around, I think this should be, "FMA and what we as members can do for medicine and our community." One of the greatest areas where the FMA can be helpful is in communication. There is still a problem with public relations between AMA and the practicing physicians. The AMA newsletter and the throw-away papers have been a help in keeping the physician informed; however, the Florida Medical Association also has a problem in communication between the state office and the practicing physician. In all probability this may not be the fault of the Florida Medical Association; however, it becomes a problem because frequently the practicing physician does not take time to read the communication when it comes to his office. It will be necessary for continued efforts along communication lines.

Medicare has aggravated our public relations problems between our Blue Cross-Blue Shield of Florida and the practicing physicians. I am afraid the Blues have taken the blame for some of the demands and requirements of Medicare; continued effort will be required to eliminate some of the criticisms that our membership has had for Blue Shield. This may be, however, because of lack of participation by some of our membership in FMA meetings and Blue Shield meetings.

One area where help may be needed is to encourage county societies to ask for help from FMA in solving local problems. It might also be helpful to write up some guidelines or suggestions as to how to develop resolutions so that we could encourage problems to be brought to FMA in the form of proper resolutions, clearly outlining the situation or problem and giving direction as to how the resolves should read to include what is necessary to make them appropriate, practical and useful.

Back to the original question, FMA and what it can do, I am looking forward to a very great year, 1973-74, and if I can do anything to help, do not hesitate to call upon me.

DONALD G. NIKOLAUS, M.D.  
DUNEDIN

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# Rondomycin<sup>®</sup> (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE:** Adults—600 mg daily, divided into two or four equally spaced doses.

More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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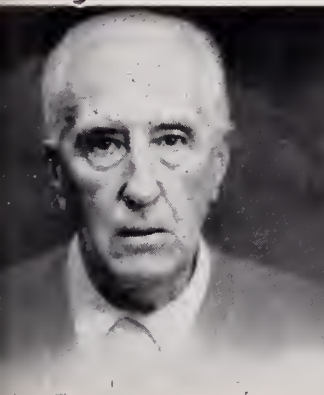
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## Book Reviews

**American Physicians in the 19th Century, From Sects to Science** by William G. Rothstein. 362 Pp. Price \$15.00, Baltimore, Johns Hopkins University Press, 1972.

This book examines the forces and influences on the private physician of the 1800's. It covers concisely the state of medical knowledge, pressures and demands of the patients themselves, causes for the rise of medical licensure and the emergence and decline of eclecticism and homeopathy.

Rothstein, a sociologist specializing in the sociology of professions, points out that when physicians become dependent upon each other for services, then professional societies are likely to form. Further, when certain medical services are in frequent demand, some physicians will begin to perform this service exclusively—then the specialist arises.

The medical use of cocaine was responsible, in large part, for the emergence of ENT as a specialty.

Homeopathy arose at a time when regular physicians were expending a great effort, often to the patient's detriment, with bloodletting and the administration of calomel; however, they satisfied the need of patient and physician to do something dramatic! At least the patient of the homeopath would not be injured by the diluted-ineffective medicine.

In the 1880's when regular physicians became a bit more scientific and consequently somewhat more effective, a segment of homeopaths called *low-dilutionists* were becoming more like regular physicians. The AMA made it possible for homeopaths to become regular physicians merely by renouncing homeopathy. At the same time, homeopathic schools were changing to "regular" courses; hence, the homeopathic problem was resolved by amalgamation. This is analogous to the situation in California of a decade ago when

the osteopath could get his M.D. merely by trading in his D.O.!

Rothstein also discusses the differences in philosophy and function of *inclusive* medical organizations such as the AMA and state medical societies versus the *exclusive* organizations such as specialty societies. The inclusive organization is necessary because one is less likely to be able to regulate the activities of a physician if he is outside the group. On the other hand, the exclusive medical organizations tend to emphasize their *differentness* and presumed superiority over the average physician by virtue of special training, special competence or adherence to a superior code of ethics.

Although this book will have a limited appeal, it contains special rewards for the medical history buff and the organization-watcher.

F. NORMAN VICKERS, M.D.  
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**Management of Constipation** by Sir Francis Avery Jones and Edmund W. Godding. Pp. 197. \$8.00 Paperbound. Blackwell Scientific Publications, Oxford; U.S. Distributors, F. A. Davis Company, Philadelphia, 1972.

This is an excellent work. It should appeal to a wide range of physicians, both generalists and specialists. It reviews in a succinct manner the physiology of the colon. There are chapters on the management of constipation in adults, geriatrics, pediatrics and obstetrics.

The authors stress a physiologic approach to the management of constipation. It is recommended for all physicians who must regularly or occasionally give medical advice on this frequently troublesome subject.

F. NORMAN VICKERS, M.D.  
PENSACOLA



## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**The Causes, Ecology and Prevention of Traffic Accidents** by H. J. Roberts, M.D. Price \$39.50. 1,016 Pages. Springfield, Illinois, Charles C. Thomas Publishers, 1971.

**Principles of Clinical Electrocardiography**, 8th Edition, by Melvin J. Goldman, M.D. Pp. 400. Illustrated. Price \$8.00. Los Altos, California, Lange Medical Publications, 1973.

**Anesthesiology Progress Since 1940** by E. M. Papper, S. H. Ngai and Lester C. Mark. Pp. 192. Price \$7.95. Coral Gables, Florida, University of Miami Press, 1973.

**The First Five Years** by Virginia E. Pomeranz, M.D. with Dodi Schultz. Pp. 248. Price \$6.95. Garden City, New York, Doubleday & Company, Inc., 1973.

**The Second World Conference on Smoking and Health** edited by Robert G. Richardson. Pp. 237. Illustrated. Price \$5.50. New York, Pitman Publishing Corporation, 1971.

**Review of Medical Physiology** by William F. Ganong, M.D. 6th ed. 578 pages. Illustrated. Price \$9.00. Los Altos, California, Lange Medical Publications, 1973.

**Review of Physiological Chemistry**, 14th ed. by Harold A. Harper, Ph.D. 545 pages. Illustrated. Price \$8.50. Los Altos, Calif., Lange Medical Publications, 1973.

**Synoptic Functional Neuroanatomy** by Wendell J. S. Krieg, Ph.D. 74 pages. Illustrated. Price \$6.00 (cloth), \$5.00 (paper). Evanston, Ill., Brain Books, 1973.

**Seeing and the Eye** by G. Hugh Begbie. 227 pages. Illustrated. Price \$2.95. New York, Anchor Press/Doubleday, 1973.

**Dr. Thompson's New Way For YOU to Cure Your Aching Back** by Jess Stearn. 203 Pages. Illustrated. Price \$7.95. New York, Doubleday & Company, Inc., 1973.

## Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

**Author Responsibility.** The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

**Synopsis-Abstract.** All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

**References.** The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

**Illustrations.** Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

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## Medical News

### Miami Hires Nobel Laureate

Earl W. Sutherland Jr., M.D., who won the 1971 Nobel Prize for Medicine and Physiology, has joined the University of Miami School of Medicine as Distinguished Professor of Biochemistry.

At Miami, Dr. Sutherland will continue his research into the intricate chemical reactions which enable hormones to control the body's metabolism by initiating changes in cellular activity. While working at Vanderbilt University as Distinguished Professor of Physiology, Dr. Sutherland won the Nobel Prize for his discovery of the role of a substance called cyclic AMP.

A native of Kansas, Dr. Sutherland received his M.D. degree from Washington University School of Medicine in St. Louis in 1942.

The University of Miami also announced that Dr. Sutherland's wife, Claudia Sutherland, Ph.D., had joined the School as Assistant Dean for Research Coordination. Her professional field is pharmacology.

### Majority Rights Bill

The following is the text of the law extending majority rights to 18-year-olds that went into effect in Florida on July 1, 1973:

AN ACT relating to the rights of majority; creating section 1.01(14), Florida Statutes; providing a definition of minor; providing that the disabilities of nonage shall be removed for all persons of eighteen years of age or older; providing that this act shall not affect court-ordered support; providing a severability clause; providing an effective date.

*Be It Enacted by the Legislature of the State of Florida:*

Section 1. Subsection (14) of section 1.01, Florida Statutes, is created to read:

1.01 Definitions.—In construing these statutes and each and every word, phrase or part hereof, where the context will permit:

(14) The word "minor" includes any person who has not attained the age of 18 years.

Section 2. The disability of nonage is hereby removed for all persons in this state who are 18 years of age or older and they shall enjoy and suffer the rights, privileges and obligations of all persons 21 years of age or older except as otherwise excluded by the Constitution of the State of Florida immediately preceding the effective date of this act. Provided, however, this act shall not prohibit any court of competent jurisdiction from requiring support for a dependent person beyond the age of 18 years; and provided further that any crippled child as defined in chapter 391, Florida Statutes, shall receive benefits under the provisions of said chapter until age 21, the provisions of this act to the contrary notwithstanding.

Section 3. This act shall operate prospectively and not retrospectively and shall not affect the rights and obligations existing prior to the effective date of this act.

Section 4. Any law inconsistent herewith is hereby repealed to the extent of such inconsistency. In editing the manuscript for the next revision of the Florida Statutes, the statutory revision and indexing service is hereby directed to conform existing statutes to the provisions of this act.

Section 5. In the event that any provision or application of this act is held to be invalid, it is the legislative intent that the other provisions and applications hereof shall not be thereby affected.

Section 6. This act shall take effect July 1, 1973.

### Compensation Law Amended

Members of the Florida Medical Association are reminded that their office practices may now be affected by the 1973 amendments to Florida's Workmen's Compensation Law.

As of last July 1, any employer having one or more workers employed at any time must secure the payment of compensation in case of accidental injury to the employee.

Parttime workers are covered, as are officers of a corporation who perform services for remuneration for such corporation.

The Florida Bureau of Workmen's Compensation advised employers to purchase the coverage through the casualty insurance agents of their choice.

# MEETINGS

Approved by FMA  
Committee on Continuing Education

## SEPTEMBER

- 15-16 A Symposium on "Endocrinology: Diagnosis and Management of Endocrine Problems," St. Vincent's Medical Center (Schultz Auditorium). For information: Yank D. Coble Jr., M.D., 2700 Riverside Ave., Jacksonville 32203.

## OCTOBER

- 12-14 Florida Region of American College of Physicians and Florida Society of Internal Medicine, Innisbrook, Tarpon Springs. For information: Chester Cassel, M.D., 1150 N.W. 14th St., Miami 33136.
- 26-27 Postgraduate Course in Otolaryngology for the Family Practitioner, Playboy Plaza, Miami Beach. For information: Bruce W. Weissman, M.D., Box 875, Biscayne Annex, Miami 33152.
- 26-27 Twenty-First Annual Florida Diabetic Symposium, Doral Country Club, Miami. For information: Carl L. Moore, M.D., 1609 Pasadena Ave., S., St. Petersburg 33707.

## NOVEMBER

- 22 Jacksonville Hospitals Education Program Basic Science Course, Alumni Auditorium, University Hospital, Jacksonville. For information: Herbert A. Burke Jr., M.D., 655 W. 8th St., Jacksonville 32209.

1974

## JANUARY

- 2- 5 Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Eden Roc Hotel, Miami Beach. For information: Div. of Continuing Education, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.
- 6-10 Neuro-Ophthalmology Symposium, Sonesta Beach Hotel, Miami Beach. For information: Joel S. Glaser, M.D., 1638 N.W. 10th Ave., Miami 33136.

National and Regional  
Meetings Held in Florida

## OCTOBER

- 1- 5 American Association for Laboratory Animal Science, Americana Hotel, Miami Beach. Exec. Sec.: Mr. Joseph Garvey, 2317 West Jefferson Street, Joliet, Illinois 60435.
- 11-13 American Society for Colposcopy and Colpomicroscopy, Sonesta Beach Hotel, Key Biscayne. Pro. Dir.: Adolfo C. Corzo, Symposia International, P. O. Box 580, Tujunga, Calif. 91042.
- 20-21 American Association for Hand Surgery, Diplomat Hotel, Hollywood. Sec.: Kim K. Lie, M.D., 27500 Hoover Road, Warren, Michigan 48093.
- 21-26 American Society of Maxillofacial Surgeons, Diplomat Resorts, Hollywood. Sec.-Treas.: Samuel Shatkin, M.D., 50 High Street, Buffalo, N.Y. 14203.
- 21-26 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Hollywood. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

## NOVEMBER

- 5- 9 Gerontological Society, Miami Beach. Exec. Dir.: Mr. Edwin Kaskowitz, One DuPont Circle, Washington, D. C. 20036.
- 7-10 American Medical Women's Association, Palm Beach. Exec. Dir.: Mrs. Gertrude Conroy, 1740 Broadway, New York 10019.
- 11-16 American Association of Blood Banks, Miami Beach. Office Mgr.: Miss Lois J. James, 1828 "L" Street, N.W., Washington, D. C. 20036.

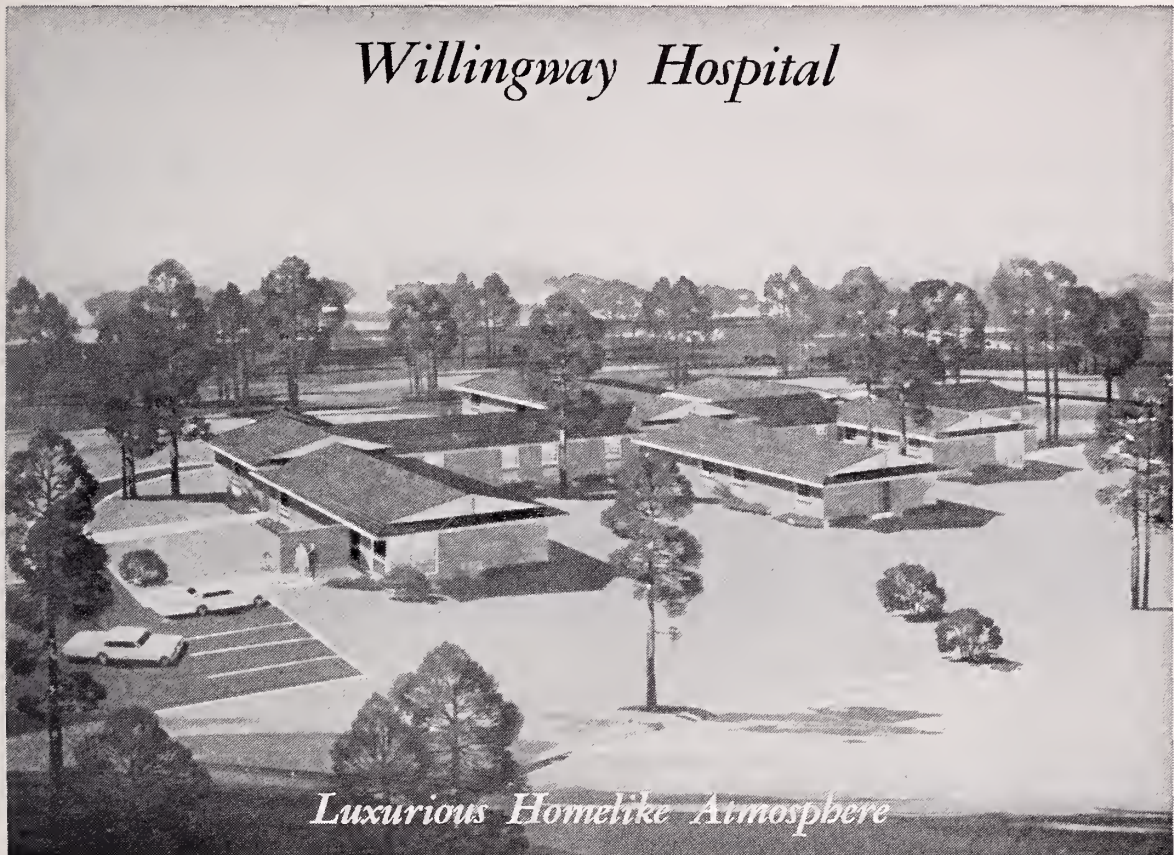
## FEBRUARY

- 10-16 The American Society of Contemporary Ophthalmology Annual Meeting, Fontainebleau Hotel, Miami Beach. For information: Miss Virginia Kendall, American Society of Contemporary Ophthalmology, 30 North Michigan Avenue, Rm. 1506, Chicago 60602.

Next FMA Annual Meeting: May 8-12, 1974, Hollywood



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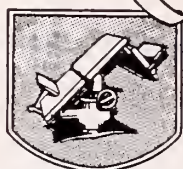
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# Florida Organizations of Medical Interest

## Meetings and Officers

Organization	President	Secretary	Annual Meeting
Florida Medical Association .....	Joseph C. Von Thron, Cocoa Bch.	James W. Walker, Jacksonville	Hollywood, May 8-12, '74
Florida Specialty Societies			
Allergy Society .....	Albert M. Ziffer, Longwood .....	Gerard F. Carter, Miami .....	
Anesthesiologist, Society of .....	Duard Lawrence, Miami .....	George T. Edwards, Ft. Lauder. ....	
Chest Phys., Fla. Chap. Am. Coll. ....	Lawrence C. Manni, Jacksonville	Roberto Llamas, Miami .....	
Dermatology, Society of .....	Robert G. Weber, Fort Lauderdale	Hillard J. Halpryn, Hialeah .....	
Emergency Phys., Fla. Chap. ....	David O. Westmark, St. Petersburg	Martin E. Amundson, Sarasota .....	
Family Physicians .....	Norman F. Coulter, Orlando .....	Joseph P. Hendrix, Port St. Joe .....	
Gastroenterologic Society .....	David Giordano, Sarasota .....	John Kennedy, Orlando .....	
Internal Medicine .....	Albert M. Ziffer, Longwood .....	Martin E. Liebling, Miami .....	
Neurology Society .....	Michael P. Goodson, Miami Beach	Richard L. Parker Jr., Winter Pk. ....	
Neurosurgical Society .....	R. Huston Babcock, St. P'berg	Ronald Sheffel, Hollywood .....	
Obst. & Gynec. Society .....	C. Herbert Gilliland, Gainesville	Henry L. Wright, Tampa .....	
Ophthalmology Society .....	T. Earle Dukes, Lakeland .....	Alfred G. Smith II, South Miami	
Orthopedic Society .....	Joseph H. Matthews, Orlando	Walter C. Jones III, Coral Gables	
Otolaryngology Society .....	William F. Shipman, Tallahassee	James Garlington, Gainesville .....	
Pathologists Society .....	Jerome Benson, Miami Beach .....	M. C. Patterson, Jacksonville	
Pediatric Society, Fla. Chap.			
Am. Acad. of Pediatrics .....	Bernard F. O'Hara, W. Palm Bch.	James M. San, Tampa .....	
Pediatric Surgeons Assn. ....	H. Warner Webb, Jacksonville	James L. Talbert, Gainesville	
Phys. Med. & Rehab. Soc. ....	George A. Cunningham, P. Bch.	Frank W. Moreau, Sarasota .....	
Plastic & Recon. Surgeons .....	Dorthea Weybright, W. P. Beach	Bernard Kaye, Jacksonville .....	
Preventive Medicine Society .....	Marshall E. Groover, Jacksonville	Sam Simpson, Bradenton .....	
Proctologic Society .....	Emmet Ferguson, Jacksonville .....	Manuel Carbonell, Miami .....	
Psychiatric Society .....	Robert L. Williams, Gainesville	Merton L. Ekwall, Tallahassee	
Radiological Society .....	Arthur R. Miller, Miami Shores	Paul A. Mori, Jacksonville .....	
Surgeons, Fla. Chap., Am. Coll. ....	David S. Hubbell, St. Petersburg	George L. Irvin III, Miami .....	
Surgeons, General, Fla. Assn. ....	John J. Farrell, Lake Worth	Robert H. Hux, Leesburg .....	
Surgeons, Surg. Div., Int. Coll. ....	Julian A. Rickles, Miami Beach		
Surgeons, Thoracic Society .....	DeWitt C. Daughtry, Miami .....	Robert B. Trumbo, Orlando .....	
Urological Society .....	John Williams, Fort Lauderdale	R. Benjamin Moore, W. P. Beach	
FLORIDA DIVISION:			
American Cancer Society .....	Malcolm S. Van de Water, P. Bch.	Mrs. T. D. Fillingim, Pensacola ....	Palm Beach, October 26-28, 1973
Arthritis Foundation .....	Samuel P. Lewis, Hollywood .....	Theodore K. Grahn, Holmes Beach	Orlando, September 1973
Blue Shield of Florida, Inc. ....	J. W. Herbert, Jacksonville .....	John S. Slye, Jacksonville .....	Hollywood, May 8-12, '74
Board of Medical Examiners .....	Vernon B. Astler, Boynton Beach	G. D. N. Bryant, Tallahassee .....	Tampa, January 27-29, 1974
Crippled Children & Adults .....	Mrs. Tom Cook, Ormond Beach .....	Milton R. Adkins, Miami .....	Miami, October 25-27, 1973
Epilepsy Foundation .....	J. Crowell, Pensacola .....	Mrs. V. W. Worledge, St. P'burg .....	June 1974
Florida Heart Association .....	Gerold L. Schiebler, Gainesville .....	Philip A. Hoche, Orlando .....	Gainesville, May 17-19, 1974
Florida Kidney Foundation .....	(not available)	(not available)	
Florida Lung Association .....	Solon J. Ellmaker, Orange Park .....	William J. Culbreath, St. P'burg .....	Jacksonville, April 25-27, 1974
Industrial Medical Association .....	James B. Hodge Jr., Tampa .....	Eugene L. Horger, Boca Raton .....	Tampa, November 1-3, 1973
Leukemia Society of America .....	Irving J. Whitman, Miami .....	Murray Dmsky, Miami .....	Miami, November 10, 1973
Mental Health Association .....	Mrs. K. C. Sloan, Ft. Pierce .....	Mr. Wes Miller, Shalimar .....	Gainesville, October 3-5, 1973
Nat'l Multiple Sclerosis .....	Palmer Brown, Memphis, Tenn. ....	N. deB. Katzenbach, N. Y. C. ....	New York City, October 15, 1973
Prevention of Blindness .....	Paul R. Bowman, Orlando .....	Doris McCullough, Tampa .....	Tampa, January 1974
Retarded Children Assn. ....	Jack G. May, Tallahassee .....	T. W. Hook, Lakeland .....	Tallahassee, September 13-15, 1973
United Cerebral Palsy .....	Thomas G. Freeman, Alta'te Spgs.	Herbert Sapp, Panama City .....	Pensacola, November 10, 1973
Woman's Auxiliary to FMA .....	Mrs. Wm. H. Mathews, Jacksonville	Mrs. Maurice Hodge, Rockledge	Hollywood, May 8-12, 1974

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

## Classified Ads

### physicians wanted

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**ASSOCIATE WANTED:** To join busy GP in Avon Park. Office is fairly new, equipped for two men, two blocks from recently remodeled Walker Memorial Hospital—in one of the less crowded areas of the state, centrally located in Highlands County. Please call collect for further details. Phone (813) 453-6694 or 453-6431.

#### Specialists

**INTERNIST, UROLOGIST.** GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

**INTERNIST,** board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

**PATHOLOGIST, AP-CP,** Florida license. Only candidates with outstanding qualifications and references need apply. Excellent group opportunity, lovely medium size Florida east coast community. Write C-607, P.O. Box 2411, Jacksonville, Florida 32203.

**ANESTHESIOLOGIST WANTED IMMEDIATELY:** Excellent group practice in Southeast Florida. Call 1 (305) 523-1568 weekdays.

**OB-GYN AND PEDIATRICIAN URGENTLY NEEDED** in expanding south central Florida town. All sports. 60 miles from coasts. GP. carrying load alone forming clinic. Florida license necessary. Call (813) 983-8531.

**OTOLARYNGOLOGIST WANTED:** Association leading to rapid partnership. Liberal initial arrangements. Florida Space area. Board qualified or certified, under age 40. All aspects of modern ENT. Phone (305) 724-2718.



**WANTED: GENERAL SURGEON**, Board certified or eligible, with Florida license. North Central Florida community inland, good financial opportunity, good hospitals, good schools. Moderate salary 1st year leading to partnership if mutually satisfactory by 4th year. Send details with biographical data. Write C-605, P.O. Box 2411, Jacksonville, Florida 32203.

**PHYSICIANS WANTED:** General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 East 25th Street, Hialeah, Florida 33013. Phone (305) 696-0842.

## Miscellaneous

**EXPANDING MULTI-SPECIALTY GROUP NEEDS:** Family practitioner, internist, ENT., urologist, orthopedic surgeon, second OB-GYN and second pediatrician. On lower west coast, 180-bed hospital under expansion, excellent income, ideal climate for young, active physician to raise a family in the heart of Florida's last water frontier. Contact R. L. Spencer, Clinic Manager, Charlotte Inter-Medic Health Center, 1120 South Tamiami Drive, Port Charlotte, Florida 33952 or call (813) 629-7501.

**DUNEDIN**, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

**PHYSICIANS NEEDED:** Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

**WANTED CENTRAL FLORIDA:** GP AND PEDIATRICIAN to join 4 man group well established in a rural community located in the heart of citrus and cattle country. New 50-bed hospital directly across from office. Excellent educational and recreation facilities. Please send curriculum vitae to Barbara C. Carlton, M.D., P.O. Box 1270, Wauchula, Florida 33873.

**PHYSICIANS WANTED:** St. Augustine (Flagler Hospital) desires the following Florida licensed physicians to meet the growing community needs: Internist, General Practitioner, E.R. Physicians, and Otolaryngologist. New professional building ready in August. Financial assistance available. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone (904) 829-5676.

**WINEMAKING**—A quiet retreat from the hectic cares and responsibilities of the day. Send for free informative catalog. Arbolyn Wines, 829 Knox Abbott, Cayce, S. C. 29033.

**INNOVATIVE PROGRAM** staffed by 12 physician group serving a student body of 22,000 students. The Student Health Service is a unit of the University Health Center with a Teaching Hospital and College of Medicine, Nursing, etc. Generalist preferred. Opportunities for joint academic appointment optional. Salary negotiable. The University of Florida is an equal opportunity employer. Call or write W. J. Coggins, M.D., Director, Student Health Service, University of Florida, Gainesville 32601. Telephone (904) 392-1165.

**DEVELOPING MULTISPECIALTY GROUP** oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Urologist, Internist, Cardiologist, Pediatrician, General Surgeon, Orthopaedist, and OB-GYN. Contact: H. D. Williams, M.D., President, Marlowe, Williams, Abbey & Sells, MDs, PA. Richey Medical Center, P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

## situations wanted

**UROLOGIST:** Canadian born, certified, Florida licensed, available immediately. Write C-609, P.O. Box 2411, Jacksonville, Florida 32203.

**LOCUM TENENS WANTED.** 52 year old family practitioner wishes to become acquainted with central Florida area by doing locum tenens starting in October or November. Would consider emergency room service. Write C-606, P.O. Box 2411, Jacksonville, Florida 32203.

**ANESTHESIOLOGIST AVAILABLE:** Board certified, married-young family, military complete, major university training (3 years)—wide clinical experience—can share inhalation therapy, open heart, etc. Florida license; desires association. Reply C-604, P.O. Box 2411, Jacksonville, Florida 32203.

**INTERNIST:** 31, Board eligible with one year training in rheumatology desires association or partnership, southeast coast or Orlando area. Military obligation complete and available July 1974. Contact Peter D. Wunsh, M.D., 11235 Oak Leaf Drive, Silver Spring, Maryland 20901.

**ALLERGIST:** Chest physician, age 43, certified allergy. Academic position university—affiliated hospital; head, chest and allergy sections. Experienced chest disease, pulmonary function lab., tuberculosis, RICU, etc. desires association with established practice, group or consider progressive hospital lab. Inquires: John McCloskey, M.D., 2380 Packard Ave., Huntington Valley, Pa. 19006.

## practice available

**FOR SALE OR LEASE:** Surgeon's office, 800 plus square feet in 30 unit attractive and fully occupied condominium medical building. Ideally located adjacent Sarasota, Florida Memorial Hospital. Newly furnished and decorated. Two completely plumbed and equipped examining rooms, with Ritter tables, overhead surgical lights, Bovie units, instruments. Entire office has maximum built-in cabinetry and working surfaces. Fully equipped laboratory and business office including copier, IBM typewriter, etc. Much good will goes with patient records. Must lease or sell immediately. Lease all at \$700/month or sell at \$60,000. Address all inquiries to 5537-23rd Street West, Bradenton, Florida 33507.

**PRESTIGE OFFICE AVAILABLE** for immediate occupancy. 1,040 square feet located directly opposite major hospital, ideal for specialty practice. Contact Dr. Leo Conn, 921 N. 35th Avenue, Hollywood, Florida 33021. Phone (305) 966-2268.

**VENICE: NEW ULTRAMODERN THREE STORY DOCTORS GARDENS BUILDING** now under construction directly opposite the Venice hospital. Occupancy January 1974. Design your office requirements while under construction. Contact: Dr. Sheldon Wald, 2700 S. Tamiami Trail, Sarasota, Florida 33579. Phone (813) 955-4323.

## real estate

**PRIVATE SUITES FOR IMMEDIATE OCCUPANCY:** New 18,000 sq. ft. building with excellent parking. South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

**OUTSTANDING LOCATION FOR SPECIALIST:** St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

**ORLANDO—MEDICAL SUITE** in modern building, prime location, near hospitals and schools, loads of parking, doctors needed in this area. Phone: (305) 293-6020.

**PROFESSIONAL OFFICES FOR RENT:** In small corner one story building, directly across from Memorial Hospital in Hollywood, Florida. Space available from 1,000 to 4,000 square feet. Interior will be finished for tenant's needs. Contact Yale Citrin, M.D., 3435 Johnson St., Hollywood, Florida 33021. Phone (305) 989-7441.

**Classified advertising rates are \$5 for the first 25 words or less and 20 cents for each additional word. Deadline is first of month preceding month of publication.**

**The Florida Medical Association offers placement assistance through the Physician Placement Service, P. O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.**

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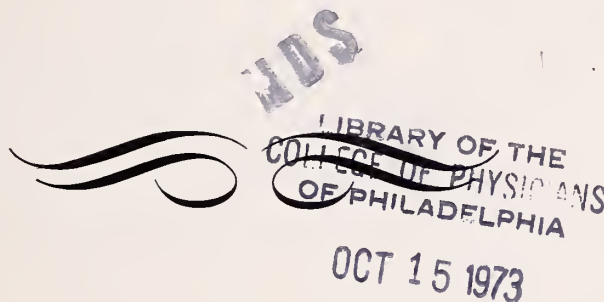
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*"Clinical medicine is an unceasing employment of means for the accomplishment of specific or definite objects. Considered in relation to our knowledge of those means, the profession is a science—in relation to the application of time, it is an art. He who acquires the former only, is learned; he who relies on the latter alone, is ignorant, empirical and criminal; he who compasses both, reaches the highest attainable perfection."*

---

*From An Inaugural Discourse on Medical Education  
(1820) by Daniel Drake, M.D.*





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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Division of Hoffmann-La Roche Inc.  
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To help you manage excessive psychic tension

# JFMA

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OCTOBER COVER—Read in a volume, given to the Editor recently by Edward Jelks, M.D., the 67th president of FMA.



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together as Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides, pregnancy and during the nursing period (see Reproduction studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

**BACTRIM**™  
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Must vasodilators  
and therapy for  
other diseases  
come into  
conflict?



not if the vasodilator is

**VASODILAN<sup>®</sup>**  
(ISOXSUPRINE HCl)

the compatible vasodilator...  
no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: *Geriatrics* 25:134-148 (May) 1970.

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## President's Page



### Nostalgia - St. Petersburg

With the recent death of John Milton, M.D., Florida medicine lost a dedicated physician and fine leader. He was President of the FMA in 1954-55 during my first days as a Florida doctor, and my Professor of Obstetrics and Gynecology at Jackson Memorial Hospital during my internship there. Over the years, Dr. Milton has been an inspiration to many of us who have served the Florida Medical Association.

It occurs to me, however, that we wait too long to praise the accomplishments of our great leaders. In most cases the eulogies are appropriate, but the expressions of respect and gratitude would have been even more appropriate while the individuals were alive to hear them. With this thought in mind, I want to use this editorial to say "Thanks" to one of the best presidents that the FMA has ever had.

Bill Dean guided Florida medicine with wisdom and dignity through a tumultuous year. He supervised the formation of three corporations: FLAMEDCO, FPA and PSRO. He enhanced his effectiveness and that of the FMA by judiciously surrounding himself with knowledgeable and energetic committee and board members and council chairmen. His board meetings were relatively brief, but they were interesting and productive.

The symbolic leader of Florida medicine spends endless hours attending committee and board meetings, reading and writing volumes of correspondence, and making public appearances. During my year of following and learning from Bill Dean I developed the highest respect for his native ability and for his willingness to apply it unselfishly in furthering the interests of the FMA. In addition to being a "work horse," Dr. Dean is a philosopher, an orator, a scholar, and a true gentleman. We, the members of Florida medicine, have benefitted greatly from his leadership.

But, that isn't all. Bill Dean had previously formed a partnership which provided a bonus benefit to the FMA. At his side throughout the presidential year was Polly, with her sparkling blue eyes and friendly, contagious smile. Polly possesses charm, charisma and dignity, all of which served her and us well as she accompanied the President to various official functions. We have been proud to have Polly Dean as our most gracious first lady.

I extend the gratitude of 8,600 physicians to two people to whom we are greatly indebted: President Bill and his charming wife, Polly.

A large, stylized handwritten signature in black ink, which appears to read "John Milton M.D.".

# Gantanol (sulfamethoxazole) and the

**0.1 M.I.C.  
for three hours**  
Similar elongations  
occur regardless of  
antibacterial used.



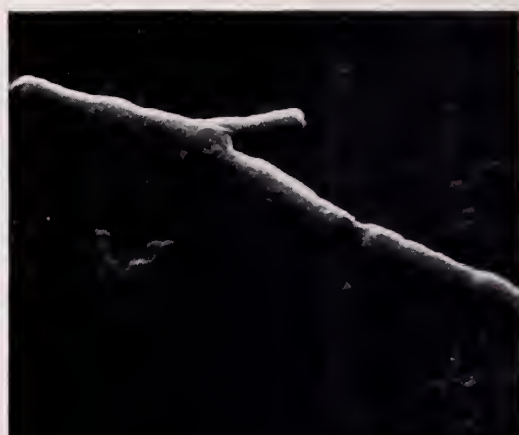
**1.0 M.I.C.  
for three hours**  
Similar midcell  
defects seen with  
increased antibac-  
terial concentrations.



**10 M.I.C.  
for three hours**  
Similar spheroplast-  
like forms appear  
with high  
concentrations of  
the antibacterials.



E. coli + sulfamethoxazole



E. coli + tetracycline

## The Scanning Electron Microscope (SEM) reveals the effect

**The *in vitro* experiment.** These SEM photomicrographs were taken as part of a study exploring the effects of various antibacterials with different modes of action on the surface morphology of bacteria. The scanning electron microscope was used because of its ability to show three-dimensional views of organisms, enabling better definition and appreciation of surface morphology.

For this portion of the experiment, *E. coli* were exposed to the following agents: sulfamethoxazole, a chemical drug which acts by interference with para-

aminobenzoic acid utilization; tetracycline, which interferes with intracellular protein synthesis; and cephalothin and ampicillin, which are cell-wall-active drugs.

Strains of *E. coli*, each susceptible to the respective antibacterials, were exposed for 15, 30, 60, 120 and 180 minutes and 18 hours to several concentrations of each agent.

Following the 180-minute or three-hour exposures to the antibacterials at 0.1 M.I.C., 1.0 M.I.C. and 10 M.I.C., photoscans of the *E. coli* were taken. As shown above, regardless of the antibacterial agent used or its mode of action, the changes in surface morphology were remarkably similar... elongation at low drug concentrations, midcell defects at higher



# Three-Dimensional World of SEM



E. coli + cephalothin



E. coli + ampicillin

## of certain antibacterials on bacterial surface morphology

concentrations and ultimate progression to spheroplast-like forms.<sup>1</sup>

**The interpretation.** "At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

**It should be noted that this information represents only *in vitro* research. No clinical significance can be drawn from this study concerning the effective-**

**ness of any of the agents discussed, as it is not possible to extrapolate *in vitro* data to humans. This information is presented to demonstrate the continuing research activities in the area of antibacterials, particularly modes of action and surface morphology.**

<sup>1</sup>Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

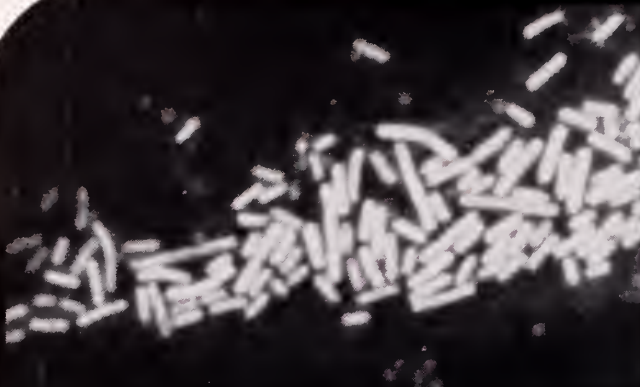
<sup>2</sup>*Antimicrob. Agents Chemother.*, 1:164, 1972.

See next two pages for product information.

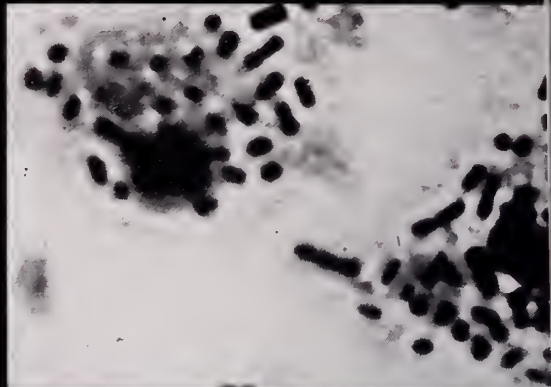
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Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Observations from



*E. coli*—Fluorescent stain



*Klebsiella* sp.—Stain to define capsular envelope

## ■ Effective control of primary susceptible bacterial offenders

Gantanol® (sulfamethoxazole) is effective against susceptible strains of *E. coli*, the most common cause of urinary tract infections. It is also highly effective against other susceptible gram-negative and gram-positive organisms, usually *Klebsiella-Aerobacter*, *Staph. aureus* and *Proteus mirabilis*.

## ■ Prompt antibacterial blood and urine levels—in from 2 to 3 hours

Antibacterial levels of Gantanol usually appear in blood and urine in from 2 to 3 hours after the initial 2-Gm adult dose. This rapid initiation of effective antibacterial activity enables prompt treatment of certain nonobstructed urinary tract infections and may also help avert possible sequelae.

## ■ Around-the-clock coverage for 14 days

Mounting evidence in current medical literature suggests a minimum of 14 days' continuous therapy for certain urinary tract infections.\* Following the initial 2-Gm adult dosage of Gantanol, each 1-Gm dose provides up to 12 hours of antibacterial activity during the treatment period. When urinary tract infection is more severe, *t.i.d.* (q. 8 h.) dosage schedule may be required. Both regimens provide around-the-clock therapy, important because normal urinary retention during sleep tends to favor bacterial proliferation. It is also convenient for patients not to have to take middle-of-the-night medication.

## ■ Also effective in certain nonobstructed chronic and recurrent urinary tract infection

Nonobstructed urinary tract infections, such as cystitis or pyelonephritis—chronic and/or recurrent—develop more commonly in the elderly and debilitated, and response to Gantanol is often highly satisfactory.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-

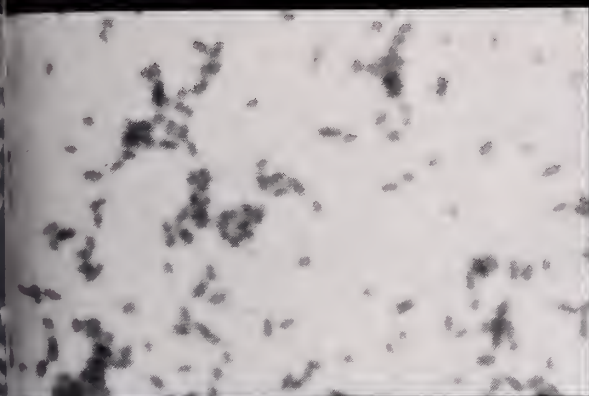
hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

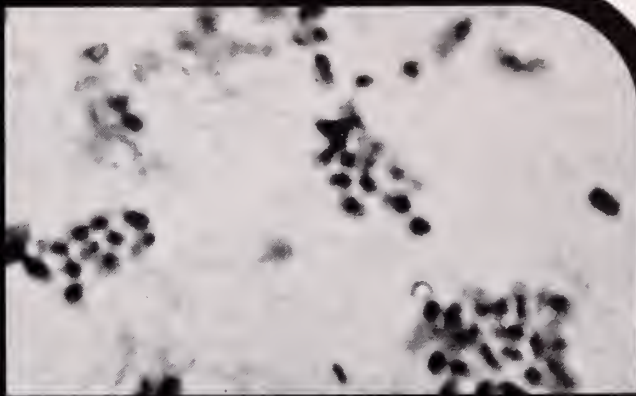
**Adverse Reactions:** Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglo-



# clinical practice



*Enterobacter* sp.—Gram stain showing characteristic gram-negative rod



*Proteus mirabilis*—Flagella stain

## ■ Your option: tablets or suspension

Gantanol Tablets or the pleasant-tasting, cherry-flavored Suspension can provide dependable antibacterial activity to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement usually may be expected to begin within 24 to 48 hours. Usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol is generally well tolerated, with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended during therapy.

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

## In nonobstructed cystitis due to susceptible organisms

# Gantanol<sup>®</sup> B.I.D. (sulfamethoxazole) Basic therapy

binemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage:** Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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## **Medical News**

### **\$1 Million Grant for Miami**

The Kresge Foundation has awarded a grant of \$1 million to the Bascom Palmer Eye Institute of the University of Miami School of Medicine.

The money will be applied to the construction of a \$9.5 million eye hospital, which was begun in April. No government funds are involved in construction of the new facility in the School of Medicine/Jackson Memorial Hospital medical complex.

### **Myeloma Symposium**

The Cancer Clinical Investigation Review Committee and the Clinical Investigations Branch of the National Cancer Institute are sponsoring a symposium on Multiple Myeloma on October 22-23, 1973, in Atlanta, Georgia at the Royal Coach Motor Hotel. The object of this symposium is to provide an updating of the present state of the art and science of multiple myeloma, of monoclonal gammopathies in general, and of clinical considerations of this group of diseases in the broadest sense.

### **Symposium on Continuing Education**

A Symposium on Continuing Medical Education will be conducted at the Admiral Benbow Inn in Tampa on Wednesday, October 24.

The program is sponsored by the Community Hospital Education Council of the State University System of Florida.

"The purpose of this symposium is to attempt clarification of areas of responsibility of the many organizations concerned with continuing medical education in the state," according to Francis C. Coleman, M.D., of Tampa, Chairman of the Council.

It is expected that participants will include members of the FMA Committee, the Community Hospital Education Council, and the Florida State Board of Medical Examiners; directors of medical education programs throughout the state; deans of medical schools; and representatives of the Florida Academy of Family Practice and other specialty groups.

### **Heart Fellowships**

The Florida Heart Association is accepting applications for 1974-75 fellowships for research in the cardiovascular field and in related problems in the basic sciences.

Individuals with doctorate degrees are eligible for the fellowships which run one or two years. Applications must be postmarked on or before November 1, 1973.

Information and application forms are available from: Florida Heart Association, Inc., P. O. Box 10100, St. Petersburg, Fla. 33733.

### **AMA Officer to Speak in State**

Malcolm C. Todd, M.D., of Long Beach, Calif., President-Elect of the American Medical Association, has accepted an invitation to address the annual meeting of the American Medical Women's Association in Florida this year.

The meeting will be held at The Breakers in Palm Beach, Florida, Nov. 9-10.

### **Infant Nutrition Conference**

A Conference on Infant Nutrition for the Practicing Physician will be held December 10-11 at the University of South Florida College of Medicine in Tampa.

A registration fee of \$50 will be charged. Information may be obtained from: James Hallock, M.D., Department of Pediatrics, University of South Florida College of Medicine, Tampa, Florida 33620.



# The Rx that says "Relax"

**BUTISOL Sodium provides highly predictable sedative effect:** minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

**BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action:** begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

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These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

\*Based on surveys of average daily prescription costs.

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(SODIUM BUTABARBITAL)

**Contraindications:** Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS<sup>®</sup> [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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### One Leg? Two Legs? Or Three Legs?

DONN L. SMITH, M.D.

For the past 30 years, medical education has adopted and fostered the achievement of three major objectives. Education, the acquisition of new knowledge, i.e., research, and the development of high caliber, sophisticated patient care at all levels. This three-legged platform has been a fully accepted major thread within the fabric of the move towards excellence in medical education. Institutions devoted time, effort and resource to progress in all three legs of the platform, with variable degrees of success. The acquisition of new knowledge in many cases was pursued with great vigor to the degree that education and patient care were overshadowed in many cases. In spite of some unbalanced operations, the activities related to high level patient care continued, and by now, medical facilities have developed enormous capabilities in patient care. In the meantime, the research capability of the nation's medical schools has been reduced by loss of what were blithely considered to be inexhaustible Federal funds. The educational component which in many areas never did receive full and adequate funding has been further compromised by what many believe to be excessive enrollment increases and by considerable shortening of the curriculum. Reduction of research activities has resulted in loss of a significant teaching and educational capability by virtue of personnel reductions from the ranks of faculty supported by "soft money."

At this point in time, it would appear that potential and long lead time losses have occurred in two of the three legs of the platform. How about the third leg, patient care? The new provisions promulgated by HR-1 for the utilization

of teaching clinicians in patient care, if not substantially revised will undoubtedly cause inroads into the patient care capabilities of the medical faculties. In addition, to the denial of some excellent medical talent to the community, losses in both teaching and research will inevitably occur. This will be the result of lost revenues to the schools which may lead to further losses in personnel. Although primarily engaged in patient care, these individuals also make sizeable contributions in both teaching and research.

Thus, it appears that we are now foreseeing a possible shortening of the third leg, i.e., patient care to be considered with the inroads in both the educational and research legs. Should we be able to accommodate and balance these shortenings, and there is no assurance that we can, what then? Will one or more of the legs be shortened beyond the point of effective function so that no balance will be possible?

The obvious conclusion is that at best, we may be exposed to a significant lowering of the entire platform of medical education by virtue of partial amputation of the three supporting legs. Even if well balanced, a lowered base of achievement or platform objectives is not a desirable situation; reduction of medical education to a trade school level is a real and frightening possibility.

As always, in medical education, at the mercy of many potent extramural forces well beyond our control, we hope and strive to do our best. The understanding and sympathy of our valued colleagues in the private practice community will be of significant help to us as we face these critical times.

► Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.



# FEEDBACK - from Pearl Street

## Sickle Cell Anemia Screening

The Hillsborough County Health Department began the first sickle cell anemia screening clinic in Florida and the first mobile electrophoresis laboratory. The Department reports the primary advantages of the mobile laboratory: 27% of abnormal hemoglobins were undetectable by the solubility method, results are available within 90 minutes, and number of screenees have more than doubled. Persons having sickle cell trait and hemoglobin C trait are counseled at the unit. Those found to have other abnormalities are referred to a physician. More than 70% of trait carriers have reported for counseling.

## Smallpox Eradication

Once smallpox is eliminated from a geographic area, it cannot return unless a new case is imported. Constant surveillance at all ports of entry and requirements that international travelers from smallpox infected areas present adequate proof of immunization upon entry have protected the United States. The disease's ancestral homeland (India, Bangladesh and Pakistan) is now being brought under jurisdiction of WHO's eradication efforts. It appears that smallpox may become the first disease ever to be eradicated since man and disease began their confrontation.

## Influenza

The new twist for influenza this year is appearance of a new type B influenza virus in December 1972. The new strain, first discovered in Hong Kong and subsequently in Australia and England, differs importantly from prior strains. Little natural immunity can be expected to exist in the general population. Further, the available bivalent influenza vaccine cannot be expected to give optimal protection against it.

Impact of the new B strain on morbidity in the United States cannot be predicted. Yet because of general susceptibility to it, widespread dissemination might be expected.

A monovalent vaccine has been prepared against the new B strain. It is commercially available and should be used to supplement the more standard bivalent vaccine among persons at high risk.

Annual vaccination is recommended for persons of all ages who have such chronic conditions as (1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; (2) chronic bronchopulmonary diseases such as asthma, chronic bronchitis, bronchiectasis and emphysema, and (3) diabetes mellitus and other chronic metabolic disorders.

Annual vaccination is recommended for older persons because influenza outbreaks are commonly associated with excess mortality in older age groups.

The primary series of bivalent influenza vaccine has traditionally been two doses. A single dose of the sharply more potent vaccines available this year should be entirely sufficient for either primary or annual booster vaccination. A single dose of the supplemental monovalent type B influenza vaccine should follow and not be given simultaneously with bivalent vaccine.

Influenza vaccination should be scheduled for completion by mid-November.

## Underwater Diving Deaths

Last year in Florida there were 27 underwater diving deaths and in the past 13 years 208, most of them among men in their early 20's. The assigned causes of death have included pressure problems such as air embolism and nitrogen narcosis, shark bites, boat propellers and heart failure. Barbiturate intoxication and alcohol have been listed as contributing causes.



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## Chemotherapy of Parasitic Diseases Commonly Seen in the United States

(Part I)

LEONARD WILLIAM SCHEIBEL, Sc.D., M.D.

**Abstract:** Parasitic diseases which occur most frequently in the United States are caused by only a very few members of three major phyla, each sensitive to specific drugs. Correct diagnosis followed by choice of the proper drug known to be effective against the particular parasite will result in high cure rates with minimum side effects.

The increase in rapid global travel, involvement in international programs (such as Peace Corps, AID, etc.) and the commitment of large numbers of troops overseas have increased the importance of parasitic infections and their current therapy. Fortunately, most parasitic diseases in themselves are rarely fatal, although malaria is still a major cause of mortality in some endemic areas and schistosomiasis is a significant contribution to the death of 2 million a year, for the most part outside the U.S. Even the nonfatal helminthic and protozoal infections acquired in the U.S. constitute a drain on human energy and vitality, especially when aggravated by malnutrition, poor living conditions, and when they are present in young children.

In the past ten years there have been many new drugs developed with very low toxicity to the host and maximum effectiveness in the treatment of these parasitic diseases. This primarily results

from selective inhibition of vital metabolic processes peculiar to the parasite and on which the host does not depend. The ideal drug should be low in toxicity to the host, selective in action against the parasite, inexpensive, palatable, and have a broad spectrum. No single drug fulfills all of these criteria. A good compromise may be obtained, however, by choosing a specific drug known to be effective against a specific organism having low host toxicity, instead of a drug with broad spectrum and moderate activity against a particular parasite, but more toxicity to the host.

Correct diagnosis, however, is still the key to using the proper drug. This paper presumes the diagnosis and deals with the therapy of infections commonly encountered in the U.S. There are some obvious omissions, i.e., toxoplasmosis, pneumocystis pneumonia, trypanosomiasis, leishmaniasis, and also the larval infections (cystercosis or hydatid disease) in which drugs are not effective forms of treatment.

### Intestinal Nematodes

*Ascaris lumbricoides* (Large roundworm)—This organism constitutes one of the most common infections of man usually producing little if any symptoms. Uncommonly, intestinal obstruction may result from large infestations; perforations and biliary obstruction from migrating worms. Piperazine citrate is still considered the drug of choice in ascariasis<sup>1</sup> and is 80-91%

Dr. Scheibel was formerly in the Department of Pharmacology and Therapeutics, University of Florida College of Medicine, Gainesville.

## DRUGS OF CHOICE FOR PARASITIC INFECTIONS

<i>Disease/Pathogen</i>	<i>Drug of Choice</i>	<i>Cure Rate</i>	<i>Dose</i>	<i>Side Effects</i>
Nematodes: <i>Ascaris lumbricoides</i>	Piperazine citrate	appx.-100%	<i>Adults</i> —single daily dose of 3.5 gm for 2 consecutive days <i>Children</i> —75 mg/kg for 2 consecutive days	weakness diarrhea urticaria blurred vision vertigo incoordination tremor
Visceral larva migrans	Thiabendazole	—	25 mg/kg BID for 10 days or 50 mg/kg QD for 10 days	weariness anorexia dizziness lack of concentration headaches nausea rash, vomiting abdominal cramps
<i>Enterobius vermicularis</i> “pin worm”	Piperazine citrate	95-100%	Single daily dose of: 50-70 mg/kg (max=2.5 gm/day) for 7-10 days	refer above
<i>Trichuris trichiura</i>	*Dichlorvos  Thiabendazole	85-94%  35%	One single oral dose of 12 mg/kg  25 mg/kg BID for 2 days	brief mild headaches depression of erythrocyte and plasma cholinesterase refer above
* This drug is not yet available				
Hookworm	Bephenium hydroxynaphthoate	75-98%	<i>Adults</i> —2.5 gm base or 5 gm of salt for 3 days <i>Children</i> —under 2 yrs. (less than 20 kg) receive half of the above dose	vomiting rarely
Cutaneous larva migrans — “creeping eruption”	1. Thiabendazole 2. Thiabendazole suspension 1% dexamethazone cream 3. 2% thiabendazole in 90% di- methylsulfoxide	—	25 mg/kg orally BID for 2-5 days  500 mg/5 ml topically topically	refer above
<i>Trichinella spiralis</i>	Thiabendazole	—	25 mg/kg BID (not to exceed 3 gm/day) for 2-4 days	refer above
<i>Strongyloides stercoralis</i>	Thiabendazole	90-100%	25 mg/kg BID (not to exceed 3 gm/day) for 2 days	refer above



curative in a single dose. The adipate, gluconate, tartrate and phosphate salts are also available. A single daily dose of 3.5 gm in adults or 75 mg/kg per day in children for 2 consecutive days will approach 100% cure rates. Purgatives are not necessary with this drug and they are actually contraindicated since they may cause the worms to migrate. One of the advantages of piperazine is the wide margin of safety between the effective therapeutic dose and the toxic dose. Toxicity, therefore, is rare but when present it may include weakness, diarrhea and urticaria, very rarely blurred vision, vertigo, and incoordination or tremor.

As alternative drugs the piperazine derivative, diethylcarbamazine may be used. It has been found active in the treatment of filariasis and ascariasis. Bephenium hydroxynaphthoate, highly effective in the treatment of hookworm, gives a cure rate of about 65% in *A. lumbricoides* infections.<sup>2</sup>

Two recently developed drugs appear to be equally as effective as piperazine. Tetramisole in a single dose of 2.5 mg/kg appears to be 90% effective against *Ascaris* but at present is not available for general use. Pyrantel pamoate in a single dose of 5 mg/lb is 90% effective, and after 2 days at this dosage it is 97% effective.<sup>3</sup> Dichlorvos in single oral doses of 6-12 mg/kg gave cure rates of 72-100%.<sup>4,5</sup> This new drug promises to be an effective anthelmintic with a broad spectrum and low incidence of toxicity.

Thiabendazole, a broad spectrum anthelmintic, has been extensively studied. At dosages of 50 mg/kg cure rates on *Ascaris* ranging between 41% to 90% have been reported.<sup>6</sup> Side effects such as dizziness, nausea, and vomiting are common and for this reason it is not considered the drug of choice for helminthic infections when equally effective less toxic anthelmintics are available. Up to one third of patients may be incapacitated, some for as long as 24 hours.<sup>7</sup>

*Toxocara canis* or *Toxocara cati* (visceral larva migrans, toxocara infections caused by the dog or cat ascarid.)—Ingestion of the eggs from the nonhuman form of *Ascaris* results in migration of the larvae through the extra-intestinal viscera characterized by fever, eosinophilia, leukocytosis and hyperglobulinemia. The asthmatic symptoms, pneumonitis and cough accompanied by splenomegaly and hepatomegaly may arouse the clinician's index of suspicion of the causative agent. The role of thiabendazole in the treatment

of visceral larva migrans is difficult to evaluate and some investigators doubt whether it significantly alters the course of the disease. Doses of 25-50 mg/kg (not exceeding 3 gm/day) over 10 days accompanied by corticosteroids<sup>8,9</sup> (20-40 mg prednisone daily, reduced after 3-5 days) and bronchodilators have been used. It has been suggested that diethylcarbamazine (120 mg three times a day for 30 days) might be more effective.<sup>10</sup>

*Enterobius vermicularis* (oxyuriasis, pinworm, or seatworm) — While this disease is not considered life-threatening, the characteristic symptom of severe anal pruritus can result in extreme discomfort. Even in an era of highly effective chemotherapeutic agents, the ease of autoinfection and direct transmission within the family unit make this disease a therapeutic challenge. Piperazine is considered highly effective in the treatment of oxyuriasis<sup>11</sup> in single daily doses of 50-70 mg/kg body weight (maximum of 2.5 gm daily) for 7-8 days. This dose will result in cures of 95-100%.

The water-insoluble pamoic acid salt of pyrantel which is not absorbed in the digestive tract has been found to give 96% cure rates in children infected with *E. vermicularis*.<sup>12</sup> Pyrvinium pamoate, a cyanine dye, in single doses of 5 mg/kg is another excellent enterobiacidal agent giving 90-100% cures but transient nausea and vomiting are common side effects.<sup>6</sup> It does not appear to be absorbed appreciably but the drug being a dye tends to stain. Thiabendazole at doses of 25 mg/kg twice a day for 2 days, not exceeding 3 gm/day, has been reported to yield 70-85% cures but associated toxicity tends to relegate it to an "alternative drug" when comparing it to more effective drugs which are now available.

*Trichuris trichiura* (trichuriasis, whipworm infection) — Until recently no drug had been found entirely satisfactory in the treatment of this infection. The cyanine dye dithiazanine iodide was found to be effective but too toxic to the host. Oral hexylresorcinol or tetrachlorethylene fail to reach the worms in sufficient concentration to be effective and hexylresorcinol retention enemas are only slightly better. Stilbazium iodide, a quaternary derivative of pyridine, gave a cure rate of 70-75%,<sup>13</sup> but it, like dithiazanine, has been removed from the market because of toxicity.

Thiabendazole at 25 mg/kg given twice daily for 2 days gives a radical cure in only 35% of cases but worm burden is reduced in many in-

stances. The accompanying nausea, vomiting, weariness, rash, dizziness, headache and erratic response of the parasite to this compound cause it not to be considered an effective drug for the infection.

The most significant advance made in this area appears to be in the development of dichlorvos. The drug may be available for investigative purposes in the near future from the Parasitic Disease Drug Service, Parasitic Diseases Branch, Center for Disease Control, Atlanta, Georgia 30333. Pharmacologically this compound is a cholinesterase inhibitor. One single oral dose of 12 mg/kg gave a cure rate of 85-94% for *Trichuris*. In those cases not cured, egg counts were reduced by 98.5%. Clinical side effects were not observed except for brief mild headaches in a few patients and depression of erythrocyte and plasma cholinesterase for 24-72 hours. Symptoms of organophosphate toxicity were not present,<sup>4, 5</sup> but some reports of acidosis have been observed.

*Necator americanus*, *Ancylostoma duodenale* (hookworm infection)—Bephenium hydroxynaphthoate is considered to be the drug of choice in hookworm disease and it also exhibits activity against other parasitic round worms to varying degrees (*Ascaris*, *Trichuris*).<sup>2</sup> This drug is not absorbed appreciably from the GI tract and only a minute amount appears in the urine in 24 hours.<sup>14</sup> Reports indicate that 1-3 courses of bephenium will eliminate hookworm in 75-98% of patients and when used in *Ancylostoma duodenale* infections, 100% cure may be realized.<sup>15</sup> A dose of 2.5 gm bephenium base or 5 gm of salt for adults and children above 2 years of age and half this amount for children under 2 years (weighing less than 20 kg) is recommended to be mixed with chocolate milk or juice to mask the bitter taste. Repetition of the same dose for 3 consecutive days will yield satisfactory cure rates in *Necator americanus* infections. The main advantage of bephenium hydroxynaphthoate is its wide margin of safety. It can be safely given to infants, pregnant women, anemic and malnourished patients and even those individuals with advanced cirrhosis and ascites with safety.<sup>16</sup> A cathartic is not necessary and cure rates may even be lowered when a purgative is used. Nutritional and iron replacement alone does not alter worm burden.

Pyrantel pamoate, which is presently not approved for the treatment of hookworm infection, showed 85% cures after a 3 day course of 5 mg/lb body weight daily<sup>6</sup> and 93-95% at 10

mg/kg with a low incidence of side effects. On the other hand, thiabendazole is not considered to be first line treatment against hookworm due to the side effects of dizziness, headaches, lack of concentration, nausea and vomiting. Cure rates are 55-80% at a dose of 25 mg/kg body weight, morning and evening for 2 days.<sup>17</sup> It may, however, have a place in the control of this disease as it inhibits the larva from developing and kills the free living larva in night soil.<sup>18, 19</sup>

The organophosphate dichlorvos, which began its career as an insecticide, so far has shown no significant toxic side effects; demonstrates a cure rate of 77-100% and reduces the egg count 97.3% in those cases not cured.<sup>4, 5</sup> The drug did not interfere with the development of hookworm eggs or the hatching of larva but very few larva survived to the infective stage. This also may help control hookworm infection in endemic areas. The drug is administered orally in hard gelatin capsules containing small resin pellets that permit slow liberation of the drug during passage through the intestinal tract. It is interesting to note that pellets voided in the fecal mass contained sufficient activity to be deadly to flies alighting on the feces several hours later.<sup>20</sup>

*Ancylostoma brasiliense* or *A. caninum* (cutaneous larva migrans or "creeping eruption") — The migration of the canine or feline hookworm larva intracutaneously in the stratum germinativum which results in erythema and intense pruritus has been successfully treated by thiabendazole. Doses of 25 mg/kg orally twice a day for 2-5 days are usually attended by the characteristic side effects of nausea, vomiting, anorexia, dizziness and abdominal cramps. Topical application, however, of a thiabendazole suspension (500 mg/5 ml) overlaid with a (1%) dexamethasone cream or 2% thiabendazole in 90% dimethylsulfoxide has shown very favorable results in this infection.<sup>21-23</sup> Dimethylsulfoxide cannot be used in the U.S. at the present time without an investigator's permit.

*Trichinella spiralis* (trichinosis)—The use of thiabendazole in the treatment of trichinosis is at present equivocal. In some instances there seems no doubt that the drug was beneficial to the patients.<sup>24, 25</sup> Some patients, however, cannot tolerate the drug.<sup>26</sup> In animal studies it has been shown that although most of the parasites might be killed with thiabendazole, the clinical condition of the animals does not improve, some dying 40-50 days after treatment. The larvae, whether



alive or dead, seem to produce a harmful effect on the host as late as 2 months post infection.<sup>27</sup> In acute infections, 25 mg/kg thiabendazole twice a day (not to exceed 3 gm/day) for at least 2-4 days accompanied by corticosteroids (20-40 mg prednisone daily, reduced after 3-5 days) seems certainly worthwhile.

*Strongyloides stercoralis* (strongyloidiasis)—Thiabendazole seems unequivocally the drug of choice for strongyloidiasis with cure rates 90-100% at doses of 25 mg/kg twice a day for 2 days (not to exceed total daily dose of 3 gm).<sup>28-30</sup> The usual side effects are headaches, dizziness and nausea. Pyriminium pamoate in a single 5 mg/kg dose has been used but is less effective than thiabendazole and it occasionally produces nausea, vomiting and diarrhea.

Part Two of this article will appear in the next issue of the Journal.

References are available upon request from the author.

## Acknowledgment

The author wishes to express his appreciation to Frank DeBusk, M.D., Department of Pediatrics; Richard Henry, M.D., Department of Community Medicine, University of Florida Health Center, Gainesville, and Edgar Steck, Ph.D., Division of Medicinal Chemistry, Walter Reed Army Institute of Research, Washington, D. C., for their critical evaluation of this manuscript.

## Addendum

For a more comprehensive discussion of these and other parasitic diseases of world importance, the reader should refer to Most, H., Drug Therapy: Common Parasitic Infections of Man, Part I, NEJM Vol. 287, No. 10, Page 495 (1972) and Part II, NEJM Vol. 287, No. 14, Page 698 (1972) which has appeared in print since this was written.

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## Use Of Physician's Name In Commercial Advertising

From time to time in the past physicians have permitted the use of their names in commercial advertisements. It was not a widespread, frequent or accepted practice.

At this time the Council sees definite evidence of a break with ethical tradition. Commercial advertisements carrying the name, photograph and professional appointments of physicians are conspicuous in both public and professional periodicals.

Regardless of disclaimers and alleged educational claims for the ad, the intent of using a physician's name and photograph in an advertisement is simply to draw attention to the ad. The physician who permits his name and photograph to be so used is permitting himself and his profession to be exploited.

The Judicial Council has previously stated that it is demeaning to the medical profession for the physician to permit the use of his name and professional status in the promotion of commercial enterprises. Out of respect for his profession, a physician should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

To the extent that the facts of a particular case indicate that the honor and dignity of the profession are denigrated then charges of conduct contrary to Section 4 of the Principles of Medical Ethics should be brought

before and fully reviewed by the ethics committee of the physician's component medical society.

Circumstances will suggest and facts disclose whether some consideration of value was given the physician for the use of his name and photograph by the advertiser. Circumstances will indicate the purpose of the advertisement.

In view of the proliferation of advertising of this nature, the Judicial Council reaffirms its opinion:

It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

In conclusion, the Council condemns as unethical the action of the physician who is found to place personal, selfish, financial, or venal interests ahead of the high ideals of the medical profession. The Council wishes to call this reaffirmation of its opinion to the attention of all physicians and to all ethical medical publications.

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Adopted by the AMA Judicial Council, April 28, 1973  
Concurred in by the FMA Judicial Council, June 30, 1973

# Rapid Treatment of Opiate Addiction and Elimination of the Withdrawal Syndrome

IRVING D. ROYCE, M.D.

**Abstract:** A case of severe opiate narcotic addiction is presented in which the patient was completely withdrawn from 30 to 40 Percodan tablets daily within ten days and without any abstinence syndrome. In addition, no other narcotic or other drug was substituted for the Percodan. The method used is dissolution of anxiety and subclinical depression through a short series of electroshock treatments in the physician's office in a specific technique described in detail. A brief history of this procedure and the theory behind this therapeutic approach are presented. It is believed that physical and/or psychological addiction to heroin, Methadone, barbiturates, amphetamines, cocaine, marijuana, alcohol, and cigarettes can also be treated similarly with equal success, and without the usual side effects of electroshock treatments.

This presentation reports the application of a theory underlying opiate addiction. The theory is that addiction is a symptom of maladaptive behavior selected by the ego in an attempt to reduce and/or to prevent the emergence of disturbing motor, sensory or autonomic effects with or without the associated memories. The disturbing effects have been observed in patients related to anxiety and/or depression. It is postulated, therefore, that a series of electroshock treatments should be capable of mollifying the depression which may become a factor in perpetuation of drug addiction. A corollary to this theory is the fact that anxiety also may be ameliorated by the treatments.

Sakel observed the anxiety syndrome in 1926 during insulin treatment of patients for morphine

abstinence.<sup>1</sup> Later he employed not only hypoglycemia but also the convulsions of artificially-induced hypoglycemia to decrease the severity of anxiety in this syndrome and in other conditions where anxiety was prominent.<sup>2</sup> Sakel and others noticed the similarity between these hypoglycemia seizures and those occurring during injections of camphor in oil introduced by Meduna in 1935.<sup>3</sup> Meduna later used Metrazol to more consistently produce seizures.<sup>4</sup> Cerletti and Bini described the technique and the first machine for producing convulsions by electricity in 1938.<sup>5</sup> Treatment of the agitation of the morphine abstinence syndrome had been discontinued; however, medical residents at Cook County Hospital in Chicago used the electrical convulsions in 1938 to control delirium tremens.<sup>6</sup>

In the present case the electrical method was utilized to produce seizures. Additionally in order to minimize confusion, amnesia and memory impairment, the unilateral method of Martin et al<sup>7</sup> was used after the patient had been put to sleep by intravenous pentothal. "Double" electroshock treatments were administered, the second one while the patient was still asleep but after spontaneous respirations became normal.

## Report of Case

The patient, a 37-year-old married man, was seen for the first time on March 28, 1973, upon referral by an emergency room physician because of alleged iatrogenic addiction to Percodan. He complained of nervousness and pain in the lower back for which he had undergone laminectomy nine to ten years previously. His facial expression showed constant and extreme tension, and marked proptosis and mydriasis were present. He did not offer information spontaneously. Verbalization was rapid, high-pitched, loud and mostly monosyllabic. He was irritable especially when refused maintenance doses of opiates. In the 24-hour period after this first visit he ingested an additional 30 Percodan tablets.



The patient had been hospitalized in September, 1972, for suspected myocardial infarction. Two years previously he had lost a considerable sum of money in a business venture and had not been able to resume gainful occupation. A second hospital admission followed for an episode of unconsciousness. During this period an exploratory laparotomy revealed a questionable volvulus of a portion of the GI tract which was corrected. He was given Percodan initially for pain then almost continuously during the last three months of 1972.

A third hospital admission in January 1973 was precipitated by abdominal pain which was described as "unbearable." Again he was treated with Percodan. After discharge he continued the Percodan in increasing doses, eventually high enough to produce lethargy and frequent sleep. During periods of wakefulness the irritability appeared to be increased. At this time he was taking 30 to 40 tablets daily. Attempting to reduce the dosage on two occasions, he was forced to turn to alcoholic beverages. He had been a heavy drinker, requiring six ounces of Scotch for relaxation.

On March 29, the day after the patient's initial visit electroshock treatments were started in the office. His wife reported he seemed more relaxed for almost 24 hours and did not take opiates. He had a double treatment daily for the next two days; then every other day for the following four days. After the second day he no longer spoke about the opiates, and by April 7 had improved to the extent that he looked for and found a full-time job. When last seen on April 12 he had worked four days and appeared relaxed, cheerful and optimistic. The eyeballs no longer bulged and the pupils were no longer dilated.

## Conclusion

A case of dramatic recovery from Percodan addiction is presented. The principal factor was use of two electroshock treatments daily for three days, followed by two treatments every other day for four days, a total of five double treatments within a period of eight days. There was no abstinence syndrome, and the patient returned to work in less than two weeks from the date of his first treatment.

It may be theorized that this same technique can be used to terminate addiction to methadone.

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## Erratum

Although last month's Journal was proofread and reviewed repeatedly by the top end of the batting order of the editorial staff, a mistake appeared unnoticed by us all, and for this we apologize. On the President's Page, the statement that "Blue Shield of Florida handles some 30,000 claims each month" should have read 30,000 each week, for example:

During the week of August 26, 1973, were received the following claims:

Blue Shield—Basic	17,041
Blue Shield—Master Medical	1,802
Federal Employee Program—Basic	3,326
Federal Employee Program—Supplemental	501
Complementary Coverage	11,126
Prescription Drug	2,662
Total	36,458

In addition to the above Blue Shield claims, also received:

CHAMPUS	3,682
Medicare Part B	54,798

# A Better Vasectomy

JOSEPH L. GREENE, M.D.

**Abstract:** The author contends that most—if not all—of the faults ascribed to vasectomies are, in fact, due to occlusion of the distal vas. A simple modification of the procedure is described that avoids such problems.

Several recent articles dwell on the many disturbances developing from vasectomies such as alterations in the 17-ketosteroids, tumors of the epididymis, pain in the testicle, and atrophy of the Leydig's cells. These and related problems are undoubtedly due to the purposeful occlusion of the vas in order to block the passage of sperm. Yet, there is no condition or situation in which the surgeon deliberately sets out to block a normal duct or tube or passage. Cutting out a piece of vas may prove something, but the only valid proof of proper surgery is the absence of sperm in the ejaculate.

Many years ago I abandoned all other methods of vasectomy that depended on ligation of the vas after many complaints of pain, pressure, and swelling of the vas, epididymis, and testicle. As pressure builds up in the entire system all producing cells have to overcome increasing resistance and must eventually become inactive and atrophic. Absolutely unnatural, unphysiologic, and undesirable!

After the vas is transected, the end of the proximal part is securely ligated—so that nothing can get into it. But note that there is no obstruction to the natural gradient of flow to the outside. The distal end—left open—is fixed to the subcutaneous tissue at the lower end of the incision (Fig. 1). With replacement of parts and closure of the wound, all layered tissues fall between the ends of the severed vas—an additional safeguard.

It was also thought that sperm could be aspirated from this site to use for insemination in case a pregnancy was to be desired at some future time. In all these years, no one has asked that this be done so I am unable to say positively that the practice would prove the theory. Perhaps "vasostomy" would be a better descriptive term for this procedure. If nature abhors a vacuum, it also equally abhors a blockage.

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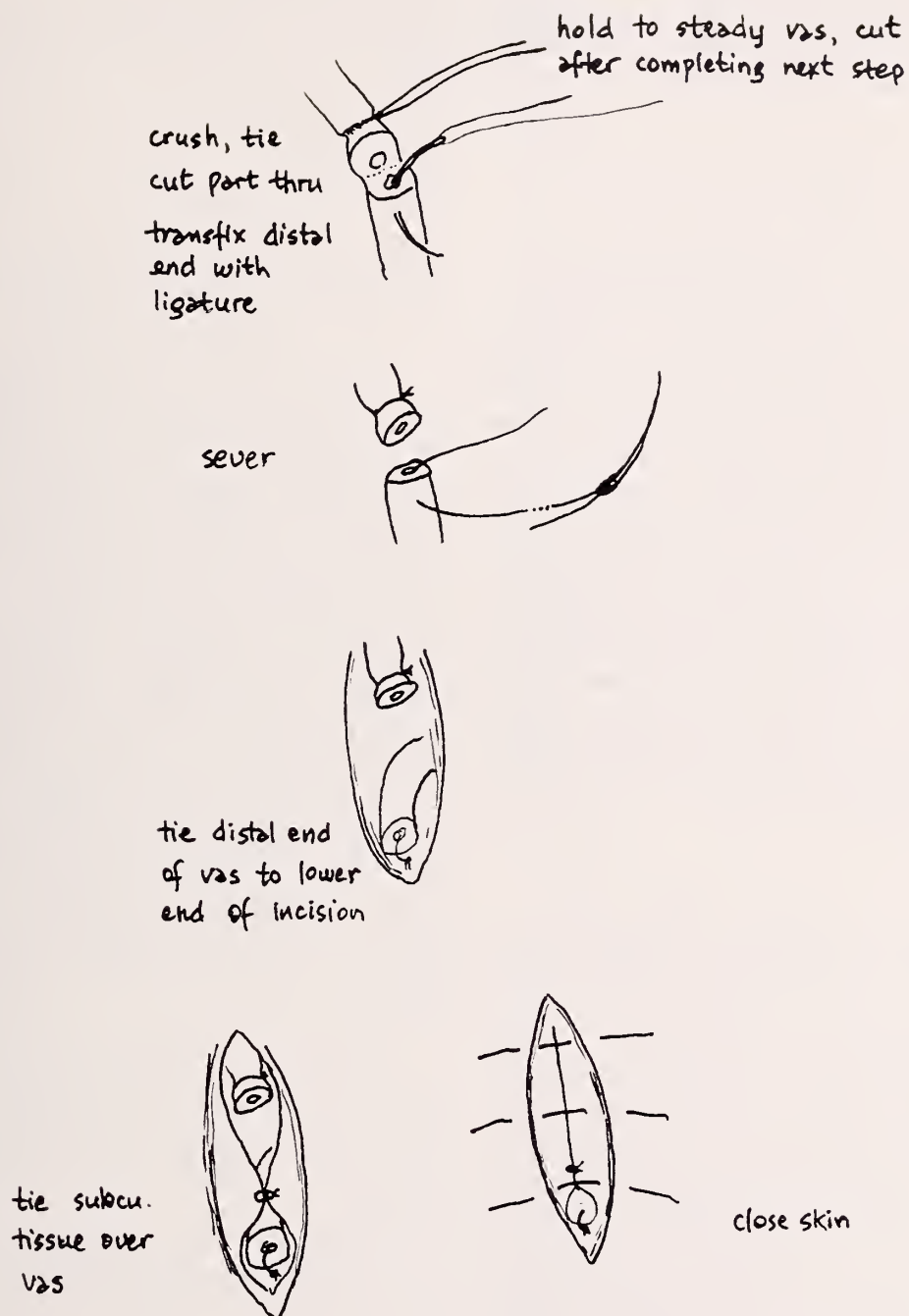


Figure 1.

# The Role of a Psychiatrist in a University Health and Counseling Center

ALFRED E. FIREMAN, M.D.

**Abstract:** The university psychiatrist as an employee of the established institution has first the task in treating students of disengaging from the real and imagined prejudgments which many of his patients possess. His theoretical base must be particularly responsive to the contemporary literature; his taste for interdisciplinary collaboration should be keen. Since he has such a unique and interesting responsibility to faculty, (colleague psychologists and physicians), clergy, administration and community, he must be inclined to function in these areas of college life. Concerning himself on the one day with student needs for rebellion, and on the other with administration's demands for control, he should possess skills as a group and family psychotherapist to moderate this dialogue. All in all his job is a most rewarding one.

Guidance, counseling, friendly listening, and modeling for identification are hardly new modes of faculty or administrator conduct. Currently, however, counseling centers have emerged with institutional directives of providing these services in a specialized way. One consequence of this separation has been a clarification of the goals, principles, and methods of the counseling process, and the emergence of much clearer lines of distinction between the techniques of education, guidance and psychotherapy.

The latter is a skill which incorporates the former two, but deals with their limitations. It is directed to underlying processes of human thinking and feelings. It defines manifest and latent interview content and in pursuit of the latter probes for the unconscious, irrational determinants of human conduct and emotion. Such so-

called insight is a frequent and many times crucial adjunct to the change and growth process.

## Relationship to Students

The search for hidden or underlying meaning was initially applied by physicians to the psychoneurotic signs and symptoms of anxiety, phobia, depression and hysterical (nonorganic or functional) physical conversion symptoms. Only in the last 15 to 20 years has this method been turned to such student complaints as boredom, sexual and personal uncertainty, and feelings of alienation and nonbeing. The former complaints have the prestige of medical illnesses and consequently one can accrue by possessing them the traditional secondary gains of sick leave, prescribed vacations, and deferment from military, domestic and industrial service. The latter complaints still suffer the stigma of malingering. Frequently candidates referred for counseling or therapy have to pass the test, "Is he really sick, and therefore entitled to forgiveness, treatment and affection; or is he a deceiver, an imposter deserving scorn, punishment and ostracism from our clinic and university?"

The limitations of such an artificial dichotomy have had a beautiful articulation by Thomas Szasz in his text, "The Myth of Mental Illness," and has a special applicability to the college community (See paragraph "4. With physician colleagues . . .").

In the college setting so focused on the conflict between rebels and establishment, the university psychiatrist must first acknowledge, and then disengage, from his history as society's once primary instrument for depriving the "different" citizens of their civil liberties (often without judicial support) by confining them in the hospitals and asylums of every state in the union. He must appreciate that while serving as director of these institutions, his predecessors served up such treat-

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Dr. Fireman was Psychiatric Consultant, Student Health and Counseling Centers, University of South Florida, Tampa.



ments as dunking, bloodletting, lobotomy, insulin comas and regressive electroconvulsive shocks, and that "progress" of his patient was most often measured by tractability and conformity. Is it any wonder that the antiestablishment young are now wary of psychiatrists employed by the state or its educational institutions?

His subject, development of the personality and psychopathology, are conversely "in" topics among students and when he is not seen as an employee of the college, his expertise in this area is provocative. The laughter and cartoons that surround his image are in some ways a decomposition of the fear and self-doubts that those who worry most about being discovered have. The myth that the real you will be discovered in your encounter with him opens up all manner of childhood guilt and shame fantasies. Thus, as real or imagined possessor of your unknown, he is awed, doubted, and disliked. Even when sought and trusted, one's relationship to the psychiatrist is never without ambivalent overtones. To be credible, the university psychiatrist must alter and reality test his mythology. Since his patients are figures of the college gestalt, he should know this society from personal experience. He should freely mix in all sectors of campus life. Not a conservative or radical by credo, he should be available to all discussions where students quest for insight into their behavior, i.e., eating in their dining halls and coffee houses, sitting in on their classes, and listening at their rallies and pop concerts.

As society's sanctioned dispenser of the legal psychotropic drugs (tranquilizers, sedatives, antidepressants), he enjoys a special place in dealing with students' legitimate concerns about other mind-blowing and consciousness-altering preparations. However, to fail to understand a student's use and abuse of marijuana, downs, ups, and hallucinogens in the context of the nation's at-large overindulgence in pain relieving, alcohol intoxicating, sleep inducing, diet, acid indigestion, and head cold remedies is to miss a crucial dimension of the rebellion; particularly because our communications to them in this area have been so blatantly absurd, misleading and downright false. Is it any wonder that they dismiss our current literature on these drugs as new hypocritical propaganda?

### Capabilities and Responsibilities

Beyond his specific physician relationship to troubled students, the university psychiatrist has

another set of service capabilities and responsibilities which he should seek to exercise and cultivate.

#### 1. With Faculty

To the Departments of Psychology, Sociology, Education, and Rehabilitation, the campus psychiatrist may be called as visiting lecturer on such topics as child development, juvenile delinquency, psychopathology, and psychopharmacology.

Also, as a student of group as well as individual psychology, he can bring the lessons and axioms of this realm to all teachers who choose to incorporate encounter and sensitivity techniques to their classroom learning situations.

#### 2. With Clergy

There is nothing in modern psychiatric theory which precludes the synchronization of mental health and an intense religious life. The root of a misconception here is the false premise that the psychiatrist bases his interrogation on a smug atheism or arrogance with regard to the issues of creation and cosmos. The fact is, however, that he is merely insisting that one offer his religious beliefs and promises to the same scrutiny that one is advised to offer all other directives of the childhood years. Thusly, one's God and one's mother must face the same evaluation if either of them are to endure as maturely loved objects, one in reality, the other on faith. In no way is there a contradiction between such an analysis and inspirational future directive incentives such as can be gotten from the writings of Tillich, Buber and Teilhard de Chardin.

#### 3. With Colleague Psychologists

The rapport between clinical psychologists and psychiatrists is unfortunately strained perforce of certain trends of history which have forced them to nurture divergent skills and methods and consequently derive separate and occasionally conflicting theories and models. Each comes to care for the emotionally disturbed student from a different data bank, training and experiential base. The university, and particularly its undergraduate colleges which already have a tradition of interdisciplinary collaboration, can bring unusual support to the task of their reconciliation, especially now that behavior modification techniques have been so favorably received at mental health clinics in the community-at-large. Part of this agreement depends on a retesting of the validity of the medical model for the formulation and treatment of all emotional and mental anguish.

The work of the clinical psychologist as a therapist is recent. Only since the early writings of the Freudian lay analysis, i.e., practitioners of the psychological healing profession without medical degrees, has the science of psychology been directed to changing, "curing" behavior of the emotionally unbalanced, by analysis. This took place almost simultaneously with a neurological literature which began to emphasize the concept of functional or nonorganic mental, motor, and sensory derangement. Although previously he was allowed the ancillary function of measuring organic deficits and normal functioning of the central nervous system, it has only been since the early 1900's that he has assumed significant responsibility for the "treatment" of individuals and the planning of public programs. Though the work of such contemporary practitioners as Kenniston, Rogers, May and Maslow certainly establish his peerage, old rivalries still persist. The University Counseling Center is an ideal forum for turning this contest into a dialogue.

#### 4. With Physician Colleagues (at the Student Health Service)

Physicians who have traditionally answered the call of the physically ailing have only been treating emotional illness since the work of Charcot in the late 1800's, and his student, Freud, who gave functional disturbances of the central nervous system their earliest definition and specialized treatment. However, many physicians still think of nonorganically "ill" people as imposters. The college physician must be cautioned not to fix on the question, "Is he really sick or overreacting," thereby failing to appreciate that by the very modality of exaggeration a student, consciously or unconsciously, makes an important statement about his emotional limitations, inadequacies, and "illness."

There is of course still plenty of mileage in the medical models for mental illness, as schizophrenia, neuropharmacology, REM phenomena, hypnosis, and electroencephalography clearly reveal. What can at long last be discarded is the myopic thinking which saw just the polar caps of sickness and nonsickness malingering, and denied the pathos and emotional bankruptcy inherent in the conscious as well as the unconscious decision to deal with one's life as an imposter, masquerading as ill. In the effort to lift these willful and less conscious distortions and repressions the preposterous distinction between legal sickness and criminal deceit will become apparent and care will be directed to the person possessed

of the troublesome behavior as the essence of their call for medical help becomes more important than their method.

Also, in a college community of basically physically healthy young people, complaints and worries about relatively minor organic lesions are often psychosomatic in the reverse sense, namely, that they generate psychological compensations with exaggerated outpourings of dependency and loneliness problems. Stated somewhat differently, in this age group the sense of being physically less than whole or well leads to tensions about being emotionally disintegrated as well. Again in this age group before other defense mechanisms against emotional problems are crystallized, there is frequently a regression to a body language, where anxiety is either in and of itself physically disabling or is translated into other physical disabilities, i.e., asthma, dizziness, lethargy and gastrointestinal distress.

#### 5. With Community

On an urban campus with an even larger percentage of commuter students, the college psychiatrist is a community mental health professional. From his training and often prior community practice experiences, he can bring to students alternate insights than others who have remained by professional necessity fixed to the campus. However, if he too abruptly turns his analytic eye from individual patients to world affairs, or city or campus politics, he jeopardizes his credibility when justly speaking in his area. Ours is a field cultured in the remarkable broth of the intuition and sensitivity of its founders, but with (even to this date) limited experimental input. Thus, it ill becomes us to speak professionally about criminality, homosexuality, women's lib, pornography and abortion, except as they are pertinent to the individual dilemma of those who consult us.

I am not here espousing a keep silent policy, for as psychiatrists we do not forfeit our right as individuals to speak on these matters. What I am against is turning the voice and authority of the profession to the task of being an official instrument for telling unusual people to be more like the rest of us, on the premise that our science truly allows us to measure their hazard or worth to society.

It is more appropriate for anthropologists, sociologists, and social psychologists whose scientific method far surpasses our own to research these problems of social nonconformity and to



propose remedies and alternatives on an urban and national level.

#### 6. With Administration

Here the college psychiatrist must define himself as the professional to whom administration can address these questions:

a. Is the student academically in over his head, i.e., does he have perceptive, incorporative or expressive neurological deficits?

b. Does he have motivation, attitude and concentration commensurate with his choice of courses and field of concentration?

c. Is he distracted from pursuit and mastery of his manifest and conscious goals by such unconscious conflicts as will produce distracting symptoms or anxiety, depression or depersonalization?

d. Does he have a shared reality with his fellow classmates and faculty?

### Special Mental Health

While so-doing, this author worked from the premise that a university should not be satisfied to simply accept the student as he is and deliver an education to him. It must rather define its relationship as an encounter which challenges students to question their latent potential and define their encumbrances to growth and change as real or mythological and in so doing achieve with his academic education his special\* mental health. This would include:

1. Establishment of a dependable pattern of sexual behavior.
2. Clarification of a personal system of values.

3. Refinement of a sense of identity.
4. Development of skills for intimacy with another person.
5. Modification of family ties with acceptance of the reality of loss and separation.

To quote a 1970 position paper of the American College Health Association on mental health, "There are as many kinds of mental health as there are individuals; each, with his unique biological equipment, past experiences, social formulation, cultural heritage and historical position, has a kind of mental health that is firsthand to him."

#### POSTSCRIPT:

Whereas it can be argued in the counsel chambers of private universities that they are autonomously in the education and not the health business, it cannot be said that states are not in the mental health business. It may eventually occur that some legislator will accordingly put the following four propositions to work as follows:

1. The State of Florida is in the mental health business.
2. The state University of Florida is in the education business.
3. A prime resource of the State of Florida is its youth and the most promising among them are enrolled in her junior and four-year college programs.
4. The greatest health hazard to this age group is emotional breakdown.

Thence may he conclude that college mental health clinics he staffed by and/or annexed to community and state mental health facilities, budgeted from their resources of local and matching federal funds. This separation has a several fold potential:

1. Fiscal relief for already overburdened college budgets.
2. A milieu for treatment of students essentially more trustworthy than conventional arrangements with split responsibility by therapists to student and employer.

(There is a less apparent advantage to the university here as well for under such circumstances administration may receive a more direct formulation of their behavior uncluttered by the intrinsic hazard of reprisal from employer.)

► Dr. Fireman, Medfield Medical Center, 12891 Seminole Boulevard, Largo 33540.

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From Dr. Russell B. Roth's inaugural address at the 122nd AMA Annual Meeting in New York City, June 27, 1973.

# MEETINGS

## Approved by FMA Committee on Continuing Education

### OCTOBER

- 12 Symposium—Highlights in Cancer 1973 for the Practicing Physician, Schultz Auditorium, St. Vincent's Hospital, Jacksonville. For information: Ashbel C. Williams, M.D., Barrs and St. Johns Ave., Jacksonville 32203.

### DECEMBER

- 10-11 Infant Nutrition for the Practicing Physician, University of the South Florida College of Medicine, Tampa. For information: Lewis A. Barness, M.D., University of South Florida College of Medicine, Tampa.

### JANUARY

- 2- 5 Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Eden Roc Hotel, Miami Beach. For information: Div. of Continuing Education, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.
- 6-10 Neuro-Ophthalmology Symposium, Sonesta Beach Hotel, Miami Beach. For information: Joel S. Glaser, M.D., 1638 N.W. 10th Ave., Miami 33136.
- 8-11 Special Procedures in Diagnostic Radiology, Playboy Plaza Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.
- 9-11 International Symposium on "Recent Advances in Clinical Electrophysiology: His Bundle Electrocardiography," Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Frances Richardson, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.
- 9-12 Postgraduate Seminar in Pediatric Neurology, Eden Roc Hotel, Miami Beach. For information: Robert Cullen, M.D., 1200 N.W. 10th Avenue, Miami 33136.

### FEBRUARY

- 22-24 Pediatric Dermatology Seminar, Fontainebleau Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

## National and Regional Meetings Held in Florida

### OCTOBER

- 11-13 American Society for Colposcopy and Colpomicroscopy, Sonesta Beach Hotel, Key Biscayne. Pro. Dir.: Adolfo C. Corzo, Symposia International, P. O. Box 580, Tujunga, Calif. 91042.
- 20-21 American Association for Hand Surgery, Diplomat Hotel, Hollywood. Sec.: Kim K. Lie, M.D., 27500 Hoover Road, Warren, Michigan 48093.
- 21-26 American Society of Maxillofacial Surgeons, Diplomat Resorts, Hollywood. Sec.-Treas.: Samuel Shatkin, M.D., 50 High Street, Buffalo, N.Y. 14203.
- 21-26 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Hollywood. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

### NOVEMBER

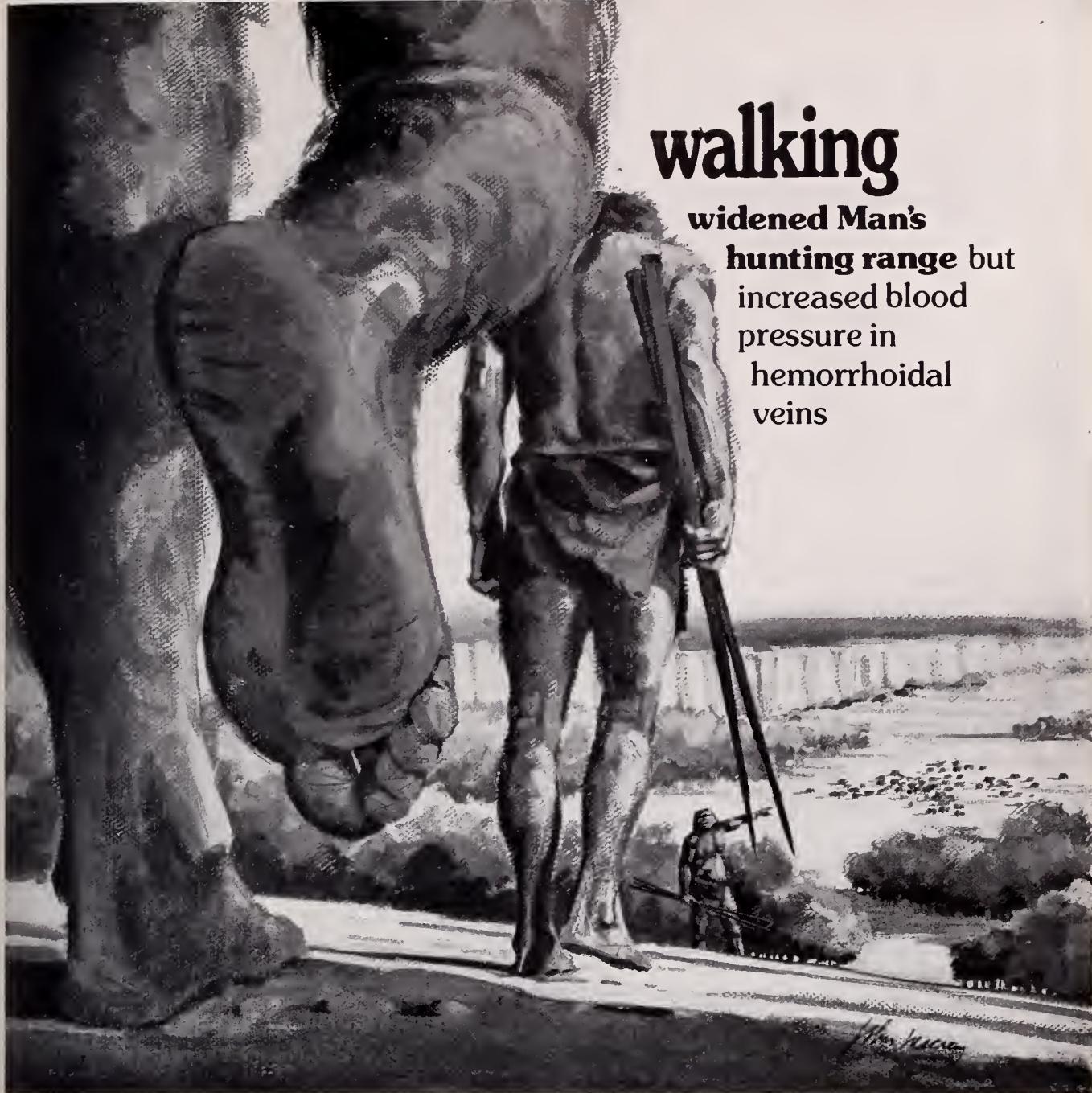
- 5- 9 Gerontological Society, Miami Beach. Exec. Dir.: Mr. Edwin Kaskowitz, One DuPont Circle, Washington, D. C. 20036.
- 7-10 American Medical Women's Association, Palm Beach. Exec. Dir.: Mrs. Gertrude Conroy, 1740 Broadway, New York 10019.
- 11-16 American Association of Blood Banks, Miami Beach. Office Mgr.: Miss Lois J. James, 1828 "L" Street, N.W., Washington, D. C. 20036.

### FEBRUARY

- 10-16 The American Society of Contemporary Ophthalmology Annual Meeting, Fontainebleau Hotel, Miami Beach. For information: Miss Virginia Kendall, American Society of Contemporary Ophthalmology, 30 North Michigan Avenue, Rm. 1506, Chicago 60602.
- 10-16 American Society of Contemporary Medicine and Surgery Annual Meeting, Fontainebleau Hotel, Miami Beach. For information: Miss Virginia Kendall, A.S.C.M.S., Rm. 1506, 30 North Michigan Avenue, Chicago 60602.

Next FMA Annual Meeting: May 8-12, 1974, Hollywood





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## Special Articles

# The 4th National Congress on Medical Ethics

WALTER H. JUDD, M.D.

As we return to our homes and regular duties, I trust that we leave with a deepened resolve to do all within our power to support and strengthen the concept of professionalism in medicine. Our speakers have not told us *what* we must think but *that* we must think—think more deeply about the meaning of the distinctions between etiquette, ethics, medical ethics, bioethics, and to observe and respect the requirements of each.

One of our first speakers said medicine today is in crisis. I agree that it is at least at a crossroads. But so is our civilization and the two are not unrelated.

There is criticism that we physicians don't live up to the ethical principles we proclaim and profess as well as in the past; that we don't practice what we preach. This criticism is not new. It has often been heard but it is more organized and strident now.

More basic is the criticism in some quarters of the ethical principles themselves. It is said that they aren't essential for our times or relevant to today's conditions and that the standards aren't necessarily good, even if we do live up to them.

Of course, this is true also of other professions. I know a young man who went into law as the profession through which he believed he could best serve his fellowman. After two years of close association with one of the top trial lawyers in a large and prestigious law firm, he was given

a case to handle on his own. When asked how it came out, his reply was, "Oh, I got him acquitted—and he's just as guilty as hell." His professional obligations to his client required that he take advantage of every technicality the law provided, doubtless under the principle that it is better to have ten guilty persons acquitted than one innocent person convicted. Yet in following those accepted standards of his profession, he knew he had defeated justice. What is a man in any profession to do when something is made legal that has previously been considered unethical?

Again and again it has been said in this Congress that our standards in medical ethics depend largely upon the general moral standards and values in the society of which we are a part, and that the kind of moral standards and values that a society develops depends in the last analysis on what the dominant elements in the society believe regarding the nature of man. What and who is man anyway? It seems clear that no matter how situations change and no matter what new knowledge and techniques are developed for treating man's illnesses, man himself is just about the same today in his appetites and aspirations, his strengths and his weaknesses, as man has always been.

Dr. Charles Malik, the eminent Lebanese philosopher and statesman, said that at the Conference on Human Rights held in Paris shortly after World War II to draw up a Universal Declaration of Human Rights the delegates spent the first several months trying, and in vain, to get agreement on what a human being is. After

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Dr. Judd is Chairman of the AMA Judicial Council. Presented before the 4th National Congress on Medical Ethics, Washington, D. C., April 28, 1973. Sponsored by the American Medical Association.



all, how do you determine and declare the rights to which every human being by nature is entitled until you decide what a human being's nature is? One main group held that man is that animal with the largest brain relative to the rest of his body, the smartest of the animals, Period. He does what he does because he's been taught to do it—completely Pavlovian. The other said that man has something in him different in character, quality, kind, from anything any animal has—specifically, the capacity to make moral judgments, and to make independent decisions based on those judgments. He has the capacity to say yes or no even in opposition to the way he's been "conditioned."

The totalitarians say we hold this view only because we have been taught it by rabbis, priests, ministers, writers of Declarations of Independence, but that it isn't so. And when nobody is permitted to plant in our minds that erroneous notion regarding the nature of man, then we won't believe it. It is their "mission" to gain control of the world—not to subjugate man but to "liberate" him from those "errors." When they control totally what is permitted to go into the human mind, they will produce a new and different human being—Communist man. He won't be acquisitive and combative as is capitalist man; he won't think in terms of the individual but in terms of the "masses;" he won't be greedy and self-seeking; there won't be clashes and, thus, there will be peace.

One day when undergoing this Communist "brainwashing" in China, I made bold to say, "I know you believe this and it sounds convincing, but I just don't believe it will work because it's against human nature." The man's eyes blazed as he exploded; "You capitalists always talk about human nature. There is no such thing as human nature. Human nature is what you make it. Capitalism makes it selfish, that's why you have wars. Communism will make it selfless and the world will at last have peace."

Well, this is still the basic question for us today: Is there such a thing as human nature or isn't there? If there is, what is it?

If there is a *moral* order in the universe—as all agree there is an astronomical order, a physical order, a biological order—how do we discover its laws or principles and apply them, or get ourselves and others to live in accordance with them? We have probed, or at least touched, such questions in this Congress and we must continue to search for the right answers to them.

Let me move on to some of the specific problems we confront in applying the principles in our practice.

Traditionally, medicine has been divided into its art and its science almost as if they were separate or separable. In days when scientific knowledge was not so highly developed, the art of medicine reached a high level of refinement and was practiced with great skill and corresponding benefit to the patient as a person. Now, in our preoccupation with the almost unbelievable expansion of scientific knowledge and technology, it is understandable that the concern of the profession as a whole for the "art" has slipped somewhat. We tend to study the patient less and less as a human being and more and more as a scientific problem—a case.

Sometimes we find ourselves treating a disease or a deformity or a dysfunction rather than the person who has it. Like the specialized garage mechanic who fixes a carburetor or the transmission or the tires, the specialist in medicine tends to treat the heart or liver, the brain or bones, more than he treats the whole human being.

Often in recent years I am with people who, knowing of my public life, forget that I am first of all a physician. They speak of our profession more freely, and the main complaint I hear is, "My doctor doesn't have time to talk to *me*."

My colleagues, our patients and the public have a right to expect that the members of this profession to which such extraordinary privileges have been given, including that of self-regulation on ethical matters, will fulfill to the highest degree their responsibilities to the whole person. Never can a true disciple of Aesculapius, no matter how busy with the body's organs, treat a patient as a soulless entity. We must get the science and art of medicine back into better balance because the art of medicine is the lifeblood of the profession. We must practice the art just as skillfully as we do the science.

Recently the press has reported incidents of medical experimentation which, if taken as true, shock the consciences of reasonable men. In one news story, a medical investigator was said to have admitted that no mother or child in the study he was conducting knew at the time that any sort of experimentation was underway. He was quoted as saying that the current requirement that any study involving experimentation on human beings must be approved by a committee that makes the investigator first get informed

consent is a step backwards. He reportedly said that if he hadn't done his study "a lot of kids" who are now receiving beneficial treatment for the particular disease wouldn't be getting that treatment. But did he have to do the experimentation the way he reportedly did?

Even the best of ends does not justify unethical means. This is never more important than in medical experimentation on human beings. We must constantly remind ourselves and urge our fellow-physicians to be alert to all of medicine's obligations; to sensitize our own consciences and those of our fellow-physicians so that medical investigation cannot be accused of failing to respect the rights of fellow human beings.

In another field the advance of science, the high costs of more complicated procedures, and the conditions of society around us today have placed an unprofessional, at times unwholesome, emphasis on the business or economic side of medical practice.

Let me emphasize and reemphasize that the laborer is worthy of his hire. The physician has not only a right, he has an ethical obligation to earn an adequate income for himself and his family. He should make appropriate charges for the medical services actually rendered by him or under his supervision to his patients. But if, *with his office full of patients*, he charges for an appointment not cancelled 24 hours in advance, he is bound to be regarded as mercenary—one who puts first not concern for the patient and the standards of the profession but dollars for the doctor.

Again, if a physician refuses, because a bill is outstanding, to forward medical information from his records to the physician who is currently treating a former patient, plainly he is putting economic interests ahead of professional interests and bringing both him and his profession into disrepute.

In an opinion of the Judicial Council a few years ago concerning physician-ownership of financial interest in hospitals, it was said, "When in the course of physician-patient relationship a conflict develops between the physician's financial investments and the physician's allegiance to his patient, the conflict must be resolved to the patient's benefit." Does not this guideline apply equally when the conflict is between the business side of a medical practice and the physician's primary obligation to his patient?

It is sometimes said that while the practice of medicine is a profession, the management of a

profession is a business. But the management of the *medical* profession is not an ordinary business because its "product" is so completely unique; it involves the very lives as well as the health of human beings.

Again, it has been argued that because credit cards have provisions for interest charges on unpaid balances, similar interest charges by physicians are quite proper. That does not follow. Credit cards are strictly a business operation; the practice of medicine is *not*.

With respect to adding interest charges on unpaid accounts, one medical group wrote to the Judicial Council, "In legal counsel's opinion, we are within our rights and legal. And our accountant feels it is good, sound, business policy." But the fact that a procedure may be both quite legal and good sound business policy does not make it an ethical procedure for a physician to use in the practice of the profession of medicine.

So, a genuinely basic and practical question which our profession, the American Medical Association as our national professional organization, and its Judicial Council must face today is this: Is it still "the prime objective of the medical profession to render service to humanity"? "Is it still true that for us financial reward or gain must be a subordinate consideration?"

If this ethical principle is not valid today, then the principle must be changed by the House of Delegates and the profession be brought down to the level of a business which makes no similar claim to being a high and noble *profession*.

If, on the other hand, this still is a valid ethical principle—*always* valid for this profession because of the preciousness of every human life and the very nature of our calling—then let us reaffirm *the* principle and rededicate ourselves to the hard but splendid task of living up to it.

Finally, let me suggest that this Congress will be meaningful to the extent that we have gained from it a sharpening of our ideas and a renewal of our idealisms, and to the extent that we take these back to our communities and put them into practice.

Is not this the best, the true way for a physician to win for himself both greater success in his practice and maximum satisfaction in his life and his ministry—the ministry of healing?

Like every useful meeting, the end of the conference is the beginning of our work.

► Dr. Judd, 3083 Ordway Street N.W., Washington, D. C. 20008.



# A Medical Inservice Continuing Education Program

## A Three Year Experience

LAMAR CREVASSE, M.D.

The Inservice Education Program offered by the University of Florida College of Medicine was funded initially by a grant from the Florida Regional Medical Program. During the first two years a stipend was given to the visiting physician; however, during the last year, due to fund reduction, no stipend was offered. The program has completed its third and final grant year.\*

Since March, 1969, 108 physicians have enrolled, with 12 enrollments in programs in adult and pediatric cardiology, cardiovascular radiology, cancer, stroke, neurology, and adult and pediatric hematology. More than 6,300 course hours of study and clinical experience have been completed. This figure does not include the number of hours spent by physicians who attend on an intermittent basis. Physicians from 31 counties in Florida and three out-of-state physicians have participated. All geographical areas of the state have been represented.

The program was designed to provide physicians with an opportunity to return to an academic environment to update their knowledge and skills. The design is flexible affording an opportunity for the physician prior to his arrival at the Health Center to outline his desired courses of study, take an active part in the development of the proposed learning experience, and play a vital teaching role as well as critique and evaluate the program. Courses are arranged on an individual basis throughout the year, and are acceptable for 40 to 80 accredited hours by the American Academy of General Practice.

Physicians participate at all levels of activity. Some prefer to observe, query, and contribute to the discussion of patient oriented problems.

Others prefer to actively teach and learn new techniques. In any event a broad spectrum of educational opportunity exists which may be tailored to the physician's particular need.

Positive demonstrations of accomplishments have been recorded, and in many instances the program has provided the physicians with technical "tools" that he can take back to his community. The physician may afford his patients the benefit of new diagnostic and/or therapeutic techniques. Some positive results include the establishment of a specialty clinic in hematology for treatment of children with cancer, implementation of an intensive coronary care unit in a small community hospital, development of an inservice training program in a local hospital, and establishment of a pediatric cardiology clinic in a remote community.

The program has given the faculty of the College of Medicine the opportunity to become intimately aware of the educational requirements of their colleagues in private practice throughout the state and the opportunity to offer innovative experience to help fulfill these needs.

At the end of the second year an evaluation workshop was conducted. Ten of the physicians who had participated in the program along with several consultants who specialize in education and research were participants. The workshop was designed to determine specifically: (1) what, if any, professional behavior changes have occurred in areas of patient management, (2) if a continuous communication link between medical school and private physicians has been established, and (3) what developments have occurred in the area of community service and education.

General conclusions of the conference include: (a) goals envisioned at the beginning of the program were slightly over ambitious, (b) participants stated a further need to strengthen recognized weaknesses, (c) the majority of participants

Dr. Crevasse is Assistant Dean for Postgraduate Medical Education and Regional Medical Affairs at the University of Florida College of Medicine, Gainesville.

\*Supported by Florida Regional Medical Program Project No. 5

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ENROLLMENT BY SPECIALTY CATEGORY  
March 1969 - February 1972

Board Certified										
Yes	No	G.P.	PEDS.	PSY.	RAD.	INT. MED.	PATH.	SURG.	NEUROL.	NONE STATED
56	52	21	22	1	4	28	1	11	6	14

RE-ENROLLMENT

Board Certified										
Yes	No	G.P.	PEDS.	PSY.	RAD.	INT. MED.	PATH.	SURG.	NEUROL.	NONE STATED
6	6	0	2	0	3	1	1	0	4	1

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New Enrollment	2,480	840		Adult 40	Ped. 40	360	880**	80
Re-enrollment	40	160				460	40	120*

\*Stroke Program—figure does not include six new enrollees and five reenrollees who attend on an intermittent basis.  
\*\*Adult Cancer Program—figure does not include one physician who attends on an intermittent basis.

recognize an awareness of new technological advances, and (d) it was impossible to measure any real stimulation by the participants toward the development of a local continuous educational program in their own communities.

In summary, the participating physicians felt that no reimbursement or stipend was necessary, and, in fact, they would be willing to pay a tuition if the program were structured to their needs. The evaluation response was unanimous in

favor of this type program as a meaningful continuing educational experience.

### Acknowledgment

This brief description of the Inservice Education Program provides only an overview. Most of the credit for its functional success resides in the participants both clinical and academic and particularly Drs. J. Russell Green and Emanuel Suter.

► Dr. Crevasse, Division of Postgraduate Education, University of Florida College of Medicine, Gainesville 32601.

By adopting Resolution 86, the AMA House of Delegates at the New York Annual Convention, reaffirmed the tradition of not withholding medical services, or performing any act interfering with public welfare. Also approved was Report F of the Board of Trustees which opposes unionism among self-employed physicians.





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**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

**Photosensitivity** manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



# CLEAR THE TRACT WITH THE ROBITUSSIN<sup>®</sup> LINE

Get the Robitussin<sup>®</sup>  
"Clear-Tract" Formulation  
Treats Your Patient's  
Individual Coughing  
Needs:

	Expectorant-Demulcent	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal Sinus Decongestant	Non-Narcotic
ROBITUSSIN <sup>®</sup>	●					●
ROBITUSSIN A-C <sup>®</sup>	●	●	●			
ROBITUSSIN-DM <sup>®</sup>	●	●		●		●
ROBITUSSIN-PE <sup>®</sup>	●				●	●
COUGH CALMERS <sup>®</sup>	■	■		■		■

Use this handy chart as a guide in selecting the formula that provides the benefits you want for your patient.

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

## For coughs of colds and "flu"

### ROBITUSSIN<sup>®</sup>

Each 5 cc. contains:  
Glyceryl guaiacolate ..... 100 mg.  
Alcohol, 3.5%

## For unproductive allergic coughs

### ROBITUSSIN A-C<sup>®</sup>

Each 5 cc. contains:  
Glyceryl guaiacolate ..... 100 mg.  
Pheniramine maleate ..... 7.5 mg.  
Codeine phosphate ..... 10.0 mg.  
(warning: may be habit forming)  
Alcohol, 3.5%

## Non-narcotic for 6-8 hr. cough control

### ROBITUSSIN-DM<sup>®</sup>

Each 5 cc. contains:  
Glyceryl guaiacolate ..... 100 mg.  
Dextromethorphan hydrobromide ..... 15 mg.  
Alcohol, 1.4%

## Robitussin-DM in solid form for "coughs on the go"

### COUGH CALMERS<sup>®</sup>

Each Cough Calmer contains:  
Glyceryl guaiacolate ..... 50 mg.  
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## Relieves cough, clears sinuses and nasal passages— keeps them "drip-dry" but not bone dry

### ROBITUSSIN-PE<sup>®</sup>

Each 5 cc. contains:  
Glyceryl guaiacolate ..... 100 mg.  
Phenylephrine hydrochloride ..... 10 mg.  
Alcohol, 1.4%

**A-H-ROBINS**

A. H. Robins Company, Richmond, Virginia 23220



## Are they too old to swing?

### EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg.
Methyltestosterone	1.25 mg.
L-lysine	100 mg.
Nicotinic Acid	12.5 mg.
Iron (from Ferrous Sulfate)	2.82 mg.
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg.
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg.
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

**ACTION AND USES—DOSAGE:** 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 30, 100, and 500 tablets.

TESTAND-B INJECTABLE: VIALS OF 10 cc

## Testand-B tablets

*A hormonal, nutritional supplement*

**Geriatric Pharmaceutical Corp.**

Floral Park, New York 11001

*Pioneers in Geriatric Research*







## Editorials

### Current Reflections on the Continuing Spectrum of Medical Care

Being primarily concerned with providing quality, continuing, comprehensive health care to the individual or family unit, I have devoted as much time as possible to participating in the education of primary health care providers. Concern about third party intervention in the private health care sector, causes me to spend more time working with legislation and regulation. Personally I am concerned about the FDA and BNDD removing drugs many of us have found useful in treatment of patients over many years time. Furthermore, I share the average citizen's perplexity about immediate availability of continuing medical care in a person's own home town. We all agree it is quite a technological feat to be able to do renal and heart transplants frequently in "Metropolis," but what about a family doctor in Podunk? or Sopchoppy? or Morning View? What happens to the starry-eyed high school graduate who embarks upon a course in medicine motivated primarily by an intense desire to help people? How does he emerge at the other end? What is the problem with funding insofar as the progressively increasing deficiency of new physicians entering the primary health care field? There are threads of interlocking continuity in all these various questions and areas of concern. Let us explore a few.

There has long been recognized a problem generated by the friction of the "town" and

"gown" physician. Take the young high school graduate who finishes premedicine and enters medical school still motivated by his sincere desire to help people. He enters into a system traditionally bound to teach how to deliver medical care and how to foster independence among patients. However, in the average academician's desire to achieve professional reputation, and in an effort to gain increasing governmental grants and supports, the primary emphasis seems to have shifted to research and the development of scientific papers. Inadvertently, the originally independent, dedicated student becomes dependent upon the institution and the equipment therein contained. He graduates unable or unwilling to practice in a rural area where he would have to work without all of the tools and consultants upon whom he has learned to depend. Those too few physicians who do separate themselves from this placental attachment to the alma mater and enter the private sector immediately become so overworked that, even if motivated to become involved in the legislative and other arenas, they lack sufficient time to do so. Moreover, the academician has scheduled inadequate time for participation in matters politic and thereby develops a sophistication relative to the degree of involvement in testimony and grant applications. All too frequently, therefore, the decisions effecting

private practice are made by academicians with little or no practical experience in the delivery of health care.

It has been a rewarding recent revelation to find men heading up departments of Family Medicine or Community Health who do not care who gets the credit for training clinicians. They are primarily dedicated to developing independent practitioners who will move out into the community and meet the challenge of primary health care for all our citizens. Such dedicated men should be clearly identified and recognized for their sacrifice, dedication and devotion.

At the same time, men with little or no clinical experience testify in areas relative to drugs and procedures that the clinician may use. Much of this responsibility has been forced upon our regulatory agencies by legislation probably well meaning in intent but implemented by people with little or no practical knowledge about the actual delivery of health care. As a result, many useful and worthwhile drugs which have stood the traditional "test of time" have been removed from our professional armamentarium. I merely refer you to the current discussion of blanket removal of all compound cough preparations and what I consider the totally unrealistic removal of methadone (Dolophine) from our available formulary. While enlightened physicians believe each of these steps inevitably lead to the so-called set formulary, many physicians are entirely too busy to become informed, much less involved. While individual clinicians and groups have been fighting the development of a fixed formulary, such fragmentation and piecemeal have combined to selectively remove from the available drug list many upon which we have learned to depend. Numerous physicians have been in the habit of using the cheapest, most effective pain and cough suppressant medication available, including methadone, and implementing this as a drug of choice. We also have used methadone as a drug of choice in inadvertently addicted or long-standing drug-dependent patients with valid medical reasons. Now such decisions are out of our hands due to the unavailability of the preparation. Its removal was based on testimony by people with limited or inadequate clinical experience in a structured situation dictated by legislation which remains totally unnecessary and impractical in the minds of many physicians.

Many hard core, long standing drug-dependent personalities have been converted into productive

and functioning citizens because of the attention provided by practicing physicians. Now, these patients will have to register with and attend special Methadone Clinics. I am sure that many more will resort to purchasing available but illegal drugs or to an increasing involvement in underworld activity including actual participation in crime to provide themselves with the drugs they need to function in our society.

Our law enforcement agencies have been made responsible for controlling or stopping the trafficking in illegal drugs. No one should or would immediately oppose this proper setting of responsibilities. However, now that methadone has been removed from our armamentarium and placed into supposed clinics which in turn foster further dependence by the individual's attending such clinics, what will be the long-range effect? It does not take a sophisticated individual to view the spiraling increases in armed robbery and burglary in pharmacies and physicians' offices. In a very short time four or five pharmacies in our particular area have been robbed and the only items taken were narcotic drugs. Cash registers and available cash were left untouched. Obviously, such law breakers were motivated not by the desire to sell something to convert into cash. They were solely interested in narcotic medication to support habits developed over a long period of time. It seems totally and completely asinine that well-meaning and educated people would impose such a situation on our citizenry making people resort to crime as a direct result of laws and regulations theoretically designed to prevent drug abuse.

I am certain that many knowledgeable people are aware of the ever-increasing perplexity and problems relative to some of the things I have discussed. However, I am not quite certain that the think tank is paying much attention to reality and can only hope that someone, somewhere will emerge to lead us with a new sense of direction and purpose.

I agree that we need to establish priorities and move to implement processes which will solve some of the problems we can identify. I do not believe we should throw out the baby with the bath water but think we should take a much more critical view of all areas of consideration involving men with practical clinical experience before arriving at irrevocable decisions.

THOMAS M. QUEHL, M.D.

► 5039 Central Avenue, St. Petersburg 33710.



## A Unified Concept of the Arthritides

The old and time-worn cliché tells us that the more things change, the more they remain the same. Indeed, as one compares the four humours of the ancients with the ying and yang of the acupuncturist one wonders where 4,000 years of medicine has led us.

Before we of the medical profession can become smug and complacent in our own advances, however, let us consider that we have merely substituted for a so-called humoral what is now essentially a biochemical approach. With the passage of time we have largely progressed in our study of disease from pathology at the organ level to pathology at the cellular level and now, finally, to pathology as expressed at the biochemical level and find that much of our morbidity resides in the aberration of cellular proteins, enzymatic processes or reactions to extraneous proteins introduced in the form of bacteria, viruses, etc. We have used this concept to explain much of what we see in a wide range of diseases varying from the so-called autoimmune disorders to neoplasia with side trips to explain aging processes in the body's tissues whether vascular, osseous or neural.

This preamble may be a useful, albeit rather superficial, and, possibly, somewhat specious, unified concept for understanding the arthritides. In such a concept, it is easy to draw an analogy between rheumatoid arthritis, disseminated lupus erythematosus and periarteritis nodosa on the one hand and gout, other metabolic bone diseases and osteoarthritis on the other inasmuch as either alteration of host protein, the presence of an abnormal enzyme or the absence of a normal enzyme help to explain the changes which one sees.

In rheumatoid arthritis and in D.L.E., for example, the reaction of the body's defense mechanism to a normal constituent as if it were a foreign substance is obvious. In gout and pseudogout, aberrations of enzymatic processes cause the accumulation of either uric acid or calcium pyrophosphate in the joints where the body then attacks them as foreign substances. In ochronosis, the absence of an enzyme causes the abnormal accumulation of homogentisic acid and, again, changes in the intervertebral discs and the peri-

pheral joints. In acute infectious arthritis, the response is either to the protein of the foreign organism itself or to foreign substances which it produces.

Finally, in osteoarthritis there has been a wealth of experimental work done recently which has a distinct bearing not only on pathology in the joints themselves but may well have significance for the general bodily processes of aging. This indicates that the presence of neutral proteases (rather than cathepsins) in excessive amounts may be responsible for much of the breakdown of the large and branching proteoglycan molecules which constitute probably the most important structure of the articular cartilage of joints. These molecules with their branching side-chains serve to retain volumes of water far in excess of their own individual size and thus help to keep in solution large amounts of minerals. They serve not only as a sponge but as a shock absorber producing a cushioning effect upon the joint. When their molecular structure is disturbed, several things occur. First, the effect on solubility is lost and calcium salts may settle out in a joint giving rise to chondrocalcinosis or pseudogout. Secondly, the cushioning effect upon the joint itself is lost and then small clefts and fissures develop in the articular cartilage. With repeated trauma, dissection of underlying osseous tissue by fluid extruded from the joint space produces subchondral cysts and erosions and the destruction of the joints resulting in the typical picture of osteoarthritis. A similar condition may exist in a somewhat different form to explain some of the changes which we see in neuropathic joints or even in some of the more inflammatory conditions such as infectious arthritis.

This brief review is not meant to indicate a feeling on the part of the author that all of these pathologies can be explained in so simplistic a manner. Rather, it is an attempt to stimulate the reader into a more thorough study of the rheumatic diseases—a study which can have many rewarding and interesting connotations.

LOUIS M. SALES, M.D.

► 1204 LeBaron Avenue, Jacksonville 32207.

# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

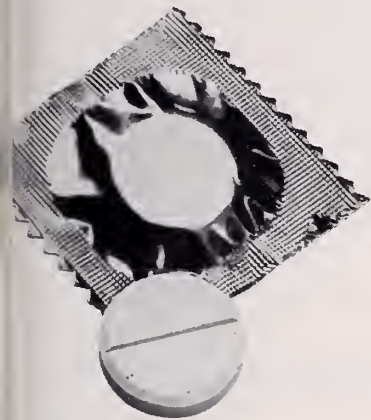
**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions



# Chewable Tablets 500 mg Mintezol® (THIABENDAZOLE | MSD)



so easy to take  
everyone in the family  
can keep to the  
regimen you prescribe

Include: fever, facial flush, chills, conjunctival injection, edema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.  
Applied: Chewable tablets, containing 500 mg thiabendazole, boxes of 36, strip packaged, individually foil wrapped; suspension, containing 500 mg thiabendazole per 5 ml, in bottles of 120 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

## INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

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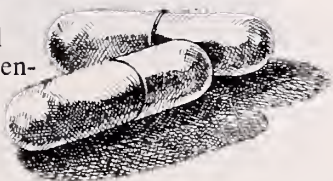




**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis adjunctive Librax®**



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110



## ORGANIZATION

### In Memoriam

**John D. Milton, M.D.**  
**1898-1973**  
**79th FMA President**

"Do all the good you can by all the means and in all the ways and places; at all times to all people and as long as ever."

After quoting his brief maxim on May 15, 1956, Dr. John D. Milton ended his term as Florida Medical Association's 79th President. It was the concluding remark of his address. In opening that address he quoted from the Proverbs: "Keep thy heart with all diligence; for out of it are the issues of life." He told his colleagues assembled at the House of Delegates that the verse had been impressed upon him by his father. They may have known that his father was a Methodist minister in Mountsville, Georgia, and that he was born there.

Keeping his heart with all diligence influenced his entire life. The conclusion which he declared in 1956 remained as a guiding principle. Between the beginning and the ending are 49 years of service to his patients and 48 to his colleagues in the medical profession. Dr. Milton was known by physicians.

Among his colleagues in the Miami area he will be remembered as president of the Dade County Medical Association, staff member of the hospitals, leader in his specialty of obstetrics-gynecology, director of the blood bank and cancer institute, president of service clubs, and steward in the Trinity Methodist Church.

He was the first professor and chairman of the Department of Obstetrics and Gynecology at the University of Miami School of Medicine.

Physicians about the state will recall his gracious presence at most FMA annual meetings, his influence in the deliberations of many committees, his work in completing the FMA headquarters building, concern with the quality of medical education, and as a member of the Board of Governors.



DR. MILTON

A physician endorsing him for the FMA Presidency remarked: "He has one rule by which he measures every problem coming before the Board of Governors; that is, what is good for the Florida Medical Association . . . with never a selfish motive in his actions."

Nationally those in his specialty will recall his guidance in many organizations as a Diplomate of the American Board of Obstetrics and Gynecology and generally for his interest in the surgical societies, AMA and Southern Medical Association.

In recent years Dr. Milton discontinued active practice to become obstetric consultant to the Florida Division of Health. The problems of practice still concerned him, however, particularly the relationship between physicians.

"Physicians . . . are all men of Medicine," he wrote. "They receive their education and training in the same schools and institutions. . . . Their outlook upon their work, its ultimate value and life in general conform with their manner of practice. . . . Yet, when the separation of special interest is such that . . . physicians do not consider themselves co-workers in one of the noblest of professions, it is time for critical reexamination. . . ."

The announcement of his death by an FMA official to the Past Presidents and members of the Board of Governors was straightforward. "It is with regret that I advise you that John D. Milton, M.D., age 75, President of the FMA in 1955, died last evening (August 16). . . . His widow's name is Kay. . . ." A noble heart ceased functioning.



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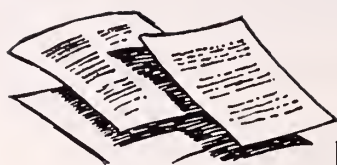
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## Letters

Dear Members of the Medical Staff:

Enclosed please find a copy of the committee appointments for the year. Any problems which arise should be brought to the attention of the Chairman of the appropriate committee. I would like to thank each one of you serving on these committees.

I have some space left and I want to quote something that has meant a lot to me. A Dr. Joseph L. Ponka said it, "We of the medical profession have a deep and abiding interest in the welfare of our patients. We become so occupied with immediate professional matters that we may overlook seemingly less urgent problems. We need to be reminded that our image in the eyes of the public stems from all facets of patient care. My comments will be applicable, more or less, to all hospitals. Their purpose is to stimulate the physician's interest in everything that happens to his patient. . . ."

It is safe to conclude that great advances have been made in scientific and technical areas of patient care in the past four decades; furthermore, appointments in the patient's room rival the comfort we provide in our homes. Color television sets, telephones, rugs and luxurious furnishings are considered necessities in many hospitals. Do not misunderstand me, I heartily approve of each of these comforts and refinements; however, there is an area which concerns me. How do we measure up in providing patient care? Are we considerate of the patient's feelings? Do we indicate that we respect the patient's privacy? Do we permit a patient who is fully intubated to walk down the corridor less than completely clothed? We hear about "delivery of medical care," much as one would deliver a bag of groceries or a C.O.D. package. What about the voice that booms out of the speaker-in-wall in a modulation that is less than gentle? We have all heard "May I help you" with the inflection in the voice hoping for a

negative reply! In carefully looking about the floors of several hospitals there does not seem to be a shortage of personnel. Paper work and records do consume much of our time, but, who has time for a word of encouragement or kindness for the patient? Are we doing our best to let the patient know we appreciate the state of his discomfiture? Let us not forget that the best therapy might result from simply listening attentively to a patient's affairs. I will not answer my own questions but, perhaps, you will draw your own conclusions.

Sir Humphry Davy, a brilliant English scientist, discoverer of sodium and potassium, made the following observations: "Life is made up, not of great sacrifices or duties, but of little things in which smiles and kindness and small obligations, given habitually, are what win and preserve the heart and secure comfort." These are gentle words, which we might well remember and apply in our daily lives.

ROBERT W. CURRY, M.D.  
PRESIDENT, MEDICAL STAFF  
ORANGE MEMORIAL HOSPITAL  
ORLANDO

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Editor's Note: The above letter was forwarded to the Editor by Bob Zellner as an example of good sound advice to physicians, and appeared worthy of publishing for all Journal subscribers to read.

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The Best way to forget about the high cost of living is to live so that life is worth more.



Dear Editor:

I have read with interest the article, "Problems in Postgraduate Education," by Nicholas S. Petkas, M.D. in the July, 1973 issue of the Journal of the Florida Medical Association. Dr. Petkas excellently summarized the problems of postgraduate education which are becoming increasingly complex. The volume of existing knowledge increases in almost logarithmic progression. Certainly today's physician needs continued education throughout his entire medical career to keep abreast of this accumulating data.

To meet such a need the Clinical Cancer Training Program of the University of Miami over the past four years has evolved a program of on-site lectures and seminars throughout the state, bringing a wide variety of cancer-related topics to the physician in his own back yard. Since the inception of this program a total of 89 conferences were given at community hospitals and medical societies in 24 different locales in Florida. These conferences were scheduled to meet the request of the host facility during the hours most convenient to the physician audience. During the past year, 1972-1973, 33 conferences were given (80 A.A.F.P. credit hours) to over 1,100 physicians throughout the state. This program has been one of the most successful in postgraduate cancer education in the nation and as such has received continuing support from the National Cancer Institute for seven years.

The development of the Comprehensive Cancer Center of Greater Miami now affords even greater capabilities in the postgraduate education area, and new and exciting educational programs similar to those cited in Dr. Petkas' article are in the process of formulation. Close cooperation and interrelationships with the various medical programs and organizations throughout the state is planned to take advantage of all available expertise in this ambitious undertaking.

HOWARD E. LESSNER, M.D.  
PROFESSOR, DEPARTMENT OF MEDICINE  
DIRECTOR, COMPREHENSIVE CANCER CENTER  
OF GREATER MIAMI

SAMUEL A. GUNN, M.D.  
PROFESSOR, DEPARTMENT OF PATHOLOGY  
CO-ORDINATOR, EDUCATIONAL PROGRAM  
COMPREHENSIVE CANCER CENTER  
OF GREATER MIAMI

Dear Editor:

First, my compliments on the courage of Dr. Wade Rizk's article on "Fee Schedule Versus Relative Value Studies" in the Journal of the Florida Medical Association of August 1973. Many barnacles of the past philosophy, activity and leadership need to be skived off before the medical profession can be accepted by the community as a dedicated group. Look back on the many programs for health care advancement which have been promulgated and look ahead to those propounded for the future and it is painfully apparent that under the guise of opposing encroachment on "Free Enterprise"—medical leadership was more concerned with the economic position of the doctor than with the societal worthiness of the plans.

May I add an ironical note that with the reasoning he has exhibited in the article he will not be among those chosen by the hierarchy for committee assignment in this field. And if to refute me he is called, the committee will be weighted against him.

Despite this, keep the banner flying.

HARRY E. BELLER, M.D.  
MIAMI



The President's Committee  
on Employment of the Handicapped  
Washington, D.C. 20210

# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# **M-M-R<sup>\*</sup>**

## **(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)**

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

### **MSD suggested immunization schedule for well babies**

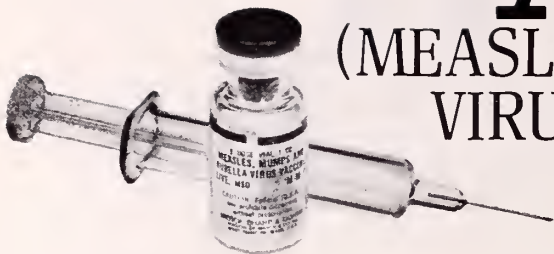
<b>Age</b>	<b>Vaccine(s)</b>
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT <sup>1</sup>
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
<b>12 MONTHS</b>	<b>M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)</b>

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

<sup>\*</sup>Trademark of Merck & Co., Inc.

**For a brief summary of prescribing information, please see following page.**



# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

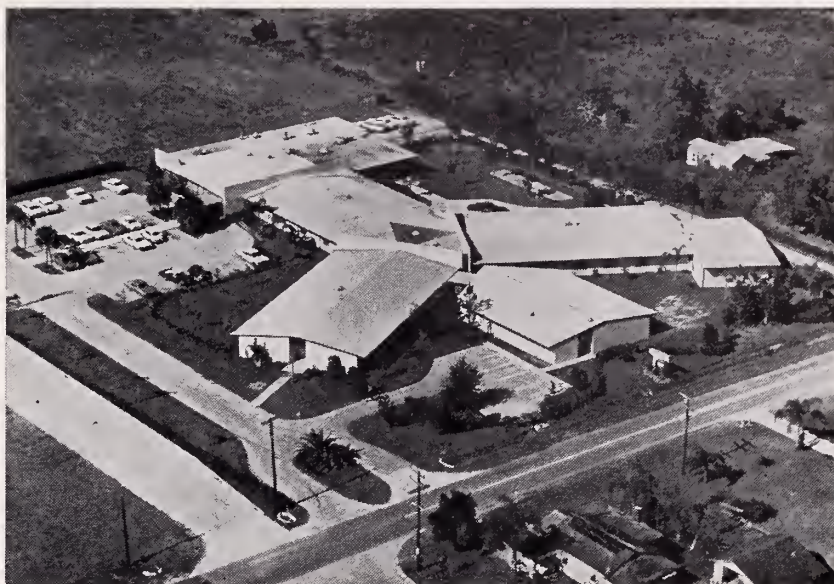
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## Book Reviews

**Nobody Ever Died of Old Age** by Sharon R. Curtin. 228 pages. Price \$6.95. Boston, Atlantic Monthly Press, Little, Brown and Company, 1972.

Written for the popular press, this book presents Ms. Curtin's experiences, thoughts and feelings while she worked and lived with the elderly in various parts of the United States. Most physicians will get few new insights into the problems of aging; however, most will be moved by her description of the experience of being aged.

"The world becomes narrower as friends and family die or move away. To climb stairs, to ride in a car . . . each action seems to take energy needed to stay alive. Everything is limited by the strength you hoard greedily. Your needs decrease, you require less food, less sleep and finally less human contact . . . You fear that one day you will be reduced to the simple acts of breathing and taking nourishment. This is the ultimate stage you dread, the period of helplessness and hopelessness, when any further independence will be over."

In preparation for writing this book, Ms. Curtin lived in "flophouse hotels" for the aged, worked as a public health nurse, explored retirement villages, and church retirement homes. She describes trying to live like her two aging men friends in the "flophouse hotel." They merely tried to survive each day and were better able to do so as a team. Shoplifting was one means of subsistence. Although she must have felt justified in doing so, her credibility declined with me when I read about these exploits. What about the ethics and morality of stealing in order to gather material for a book?

Though not likely to be of special interest for the medical reader, this book may mobilize some concern by the public for the problem of aging.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Psychosomatic Classics.** Selected papers from *Psychosomatic Medicine*, 1939-1958. Editors: L. A. Gottschalk, P. H. Knapp, M. F. Reiser, J. D. Sapira, and A. P. Shapiro. 83 illustrations. 252 pages. Price \$8.50. U.S. distributor: Albert J. Phiebig, Inc., White Plains, N.Y., 1972.

This selection of papers covers psychologic mechanisms in malignant hypertension, ovarian function, emotions and gastroduodenal function as well as the production of ulcers in "executive" monkeys.

These "classic" studies have been edited by a committee of the editorial board of *Psychosomatic Medicine*.

This book will, I believe, be of limited interest. For the newcomer to psychosomatic medicine, this may be a good place to start reading the best papers of the last two decades.

F. NORMAN VICKERS, M.D.  
PENSACOLA

### "What's Cooking, Doc?"

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Your Auxiliary offers you this book of exciting and tantalizing recipes which will not only tickle your taste buds but will also introduce you to many of the gourmet chefs among our Florida physicians and their families. Copies will be available through your local Auxiliary.

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## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**The Causes, Ecology and Prevention of Traffic Accidents** by H. J. Roberts, M.D. Price \$39.50. 1,016 pages. Springfield, Illinois, Charles C. Thomas Publishers, 1971.

**Anesthesiology Progress Since 1940** by E. M. Papper, S. H. Ngai and Lester C. Mark. 192 pages. Price \$7.95. Coral Gables, Florida, University of Miami Press, 1973.

**The Second World Conference on Smoking and Health** edited by Robert G. Richardson. 237 pages. Illustrated. Price \$5.50. New York, Pitman Publishing Corporation, 1971.

**Review of Physiological Chemistry**, 14th ed. by Harold A. Harper, Ph.D. 545 pages. Illustrated. Price \$8.50. Los Altos, Calif., Lange Medical Publications, 1973.

**Synoptic Functional Neuroanatomy** by Wendell J. S. Krieg, Ph.D. 74 pages. Illustrated. Price \$6.00 (cloth), \$5.00 (paper). Evanston, Ill., Brain Books, 1973.

**Seeing and the Eye** by G. Hugh Begbie. 227 pages. Illustrated. Price \$2.95. New York, Anchor Press/Doubleday, 1973.

**Dr. Thompson's New Way For YOU to Cure Your Aching Back** by Jess Stearn. 203 pages. Illustrated. Price \$7.95. New York, Doubleday & Company, Inc., 1973.

**Physician's Handbook** (17th ed.) by Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, M.D., Edward G. Biglieri, M.D. and Robert L. Roe, M.D. 728 pages. Illustrated. Price \$6.50. Los Altos, California, Lange Medical Publications, 1973.

**Cancer Diagnosis in Children** by L. D. Samuels, M.D. 131 pages. Illustrated. Price \$26.00. Cleveland, Ohio, CRC Press, 1972.

## Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

**Author Responsibility.** The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

**Synopsis-Abstract.** All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

**References.** The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

**Illustrations.** Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."



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## Classified Ads

### physicians wanted

#### Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

FAMILY PRACTITIONER to join 15 man multispecialty group in Central Florida. Excellent fringe benefits together with pleasant working facilities in an area famous for excellent recreational opportunities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

FAMILY PRACTITIONER to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: Middle-aged G.P. interested in being associated with another middle-aged G.P. who is trying to semi-retire. Will divide practice and responsibility, split free time and expenses. Lab and x-ray departments, together with pharmacy, included in facilities. Beautiful central Florida lakes area, two hospitals, staff positions available. Write C-608, P.O. Box 2411, Jacksonville, Florida 32203.

CENTRAL FLORIDA AREA: Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

GENERAL PRACTITIONER NEEDS ASSOCIATE immediately. Florida license necessary. Salary, then partnership. Location Lake Okeechobee. All sports. 60 miles from both coasts. 90 miles from Miami. Call (813) 983-8531.

FAMILY PRACTITIONERS WANTED: One of the fastest growing communities in the U.S., Seminole, Florida, urgently needs family practitioners. Only minutes from Tampa, St. Petersburg, Clearwater and beach areas. Newly opened 100-bed acute general hospital. Offices provided on hospital property with rent free provisions. Will assist in referrals of patients. Write or phone Carlton K. Flores, Administrator, Lake Seminole Hospital, 9675 Seminole Boulevard, Seminole, Florida, 33542. Phone (813) 393-4646.

DIPLOMATE ABFP DESIRES IMMEDIATELY: FP or GP to associate in active suburban practice Palm Beaches. Florida license required. Attractive salary, P. A. benefits and partnership opportunity. Contact J. Randolph, M.D. Phone (305) 965-8222.

#### Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST, board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

PATHOLOGIST, AP-CP, Florida license. Only candidates with outstanding qualifications and references need apply. Excellent group opportunity, lovely medium size Florida east coast community. Write C-607, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON WANTED: Certified or eligible, to take over practice of general surgery and gynecology, Palm Beach. Office for rent, equipped. Retiring January 1. Write C-612, P. O. Box 2411, Jacksonville, Florida 32203.

OB-GYN AND PEDIATRICIAN URGENTLY NEEDED in expanding south central Florida town. All sports. 60 miles from coasts. GP. carrying load alone forming clinic. Florida license necessary. Call (813) 983-8531.

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WANTED: GENERAL SURGEON, Board certified or eligible, with Florida license. North Central Florida community inland, good financial opportunity, good hospitals, good schools. Moderate salary 1st year leading to partnership if mutually satisfactory by 4th year. Send details with biographical data. Write C-605, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIANS WANTED: General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 East 25th Street, Hialeah, Florida 33013. Phone (305) 696-0842.

UROLOGIST WANTED: Association leading to partnership in expanding Florida community, equally distant from both coasts. Florida license and board certification required. Write C-614, P. O. Box 2411, Jacksonville, Florida 32203.

## Miscellaneous

**DUNEDIN**, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

**PHYSICIANS NEEDED:** Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

**INTERNIST, FAMILY PRACTITIONERS:** Central Florida area, Orange County. Area combines best of rural living with easy access to metropolitan area 11 miles away. Privileges available in expanding hospital. Contact Robert Barber, Administrator, West Orange Memorial Hospital, 555 North Dillard Street, Winter Garden, Florida 32787. Phone (305) 656-1244.

**PHYSICIANS WANTED:** St. Augustine (Flagler Hospital) desires the following Florida licensed physicians to meet the growing community needs: Internist, General Practitioner, E.R. Physicians, and Otolaryngologist. New professional building ready in August. Financial assistance available. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone (904) 829-5676.

**WINEMAKING**—A quiet retreat from the hectic cares and responsibilities of the day. Send for free informative catalog. Arbolyn Wines, 829 Knox Abbott, Cayce, S. C. 29033.

**DEVELOPING MULTISPECIALTY GROUP** oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Urologist, Internist, Cardiologist, Pediatrician, General Surgeon, Orthopaedist, and OB-GYN. Contact: H. D. Williams, M.D., President, Marlowe, Williams, Abbey & Sells, MDs, PA. Richey Medical Center, P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

**EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY:** to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of \$40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital.

**EMERGENCY ROOM PHYSICIAN** needed in 180-bed hospital located in Southwest Florida. Fast growing community, rotation with another physician. Contact Sister Mary Augustine, Administrator, St. Joseph Hospital, Port Charlotte, Florida 33952.

**WANTED:** ER physician in lovely coastal city in southwest Florida. Excellent facilities, pleasant staff relations, advanced program, quite adequate remuneration, top quality position in established program. Please send curriculum vitae and inquiries to C-613, P. O. Box 2411, Jacksonville, Florida 32203.

## situations wanted

**UROLOGIST:** Canadian born, certified, Florida licensed, available immediately. Write C-609, P.O. Box 2411, Jacksonville, Florida 32203.

**INTERNIST WITH SPECIALTY IN CARDIOLOGY:** Age 31, ABIM, university trained; desires group or associate type practice. Available summer, 1974. Write C-610, P. O. Box 2411, Jacksonville, Florida 32203.

**INTERNIST:** 31, Board eligible with one year training in rheumatology desires association or partnership, southeast coast or Orlando area. Military obligation complete and available July 1974. Contact Peter D. Wunsh, M.D., 11235 Oak Leaf Drive, Silver Spring, Maryland 20901.

**ALLERGIST:** Chest physician, age 43, certified allergy. Academic position university—affiliated hospital; head, chest and allergy sections. Experienced chest disease, pulmonary function lab., tuberculosis, RICU, etc. desires association with established practice, group or consider progressive hospital lab. Inquires: John McCloskey, M.D., 2380 Packard Ave., Huntington Valley, Pa. 19006.

**GENERALIST:** Mature, 30 years+, experience general medicine, industrial medicine, surgery. Wishes to relocate in Northeast Florida area. No OB-Surgery. Limited hours preferred, associate or share practice. Write C-611, P. O. Box 2411, Jacksonville, Florida 32203.



**ORTHOPEDIST:** Age 35, FMG, university trained, board eligible. Five years solo practice abroad. Seeks partnership or group practice, prefer with teaching/residency program in Florida. Prefer Miami area or close. Available immediately. Florida license. Fluent in Spanish and German. P. Berman, M.D., 21 Hillcrest Road, West Caldwell, N. J. 07006. Phone (201) 228-5028.

## real estate

**PRIVATE SUITES FOR IMMEDIATE OCCUPANCY:** New 18,000 sq. ft. building with excellent parking. South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

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## practice available

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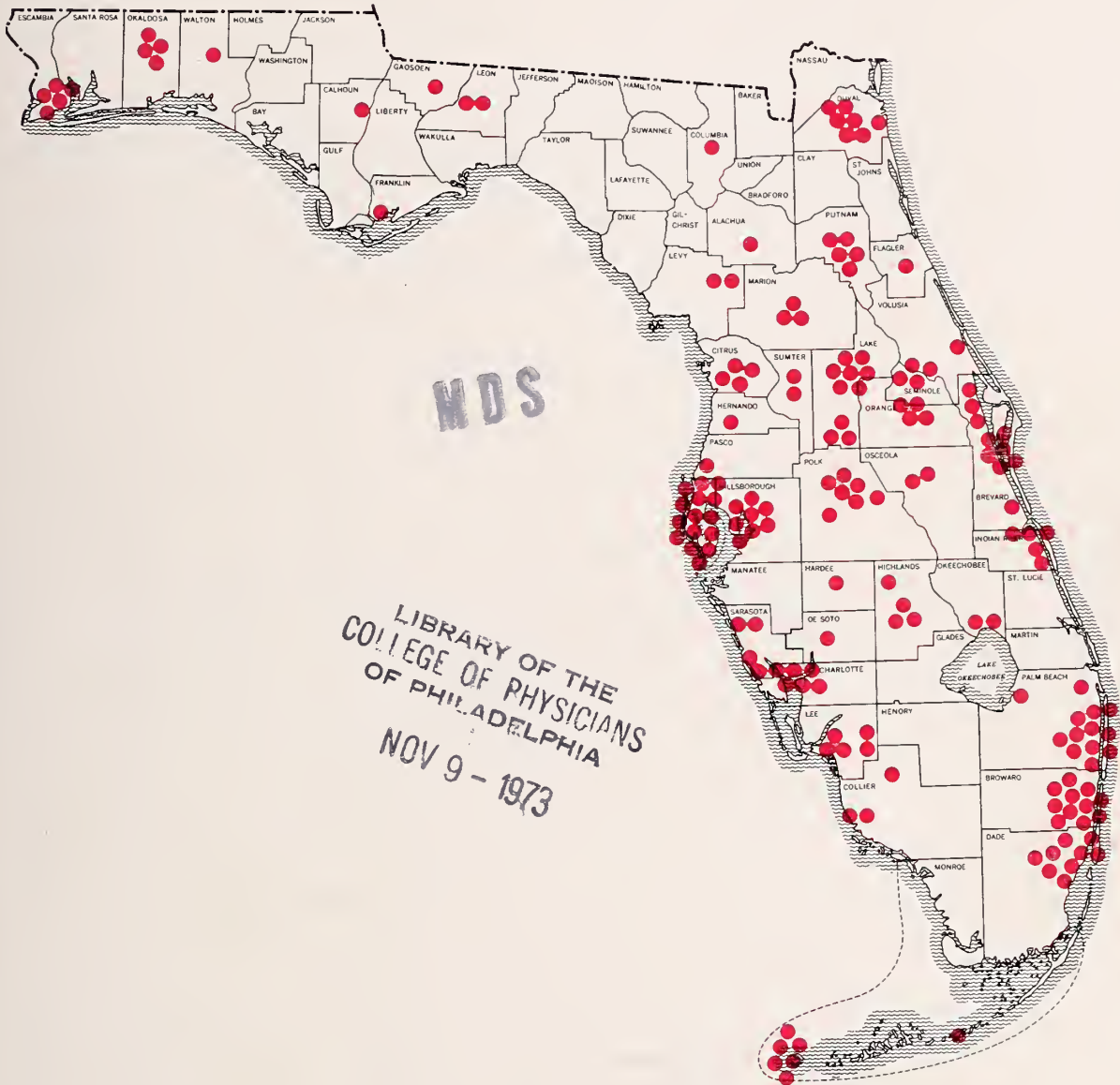
# JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.



VOL. 60, NO. 11

NOVEMBER 1973



FMA Centennial Meeting — Diplomat Hotel — Hollywood — May 8-12, 1974



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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To help you manage excessive psychic tension

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NOVEMBER, 1973 • VOLUME 60 • NUMBER 11



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NOVEMBER COVER—Our November cover shows the distribution of physician needs in Florida. Each dot represents at least one vacancy as reported to and registered with the Association's Physician Placement Service. A special article on this subject begins on page 36 of this issue.



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N<sup>1</sup>-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprote thrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

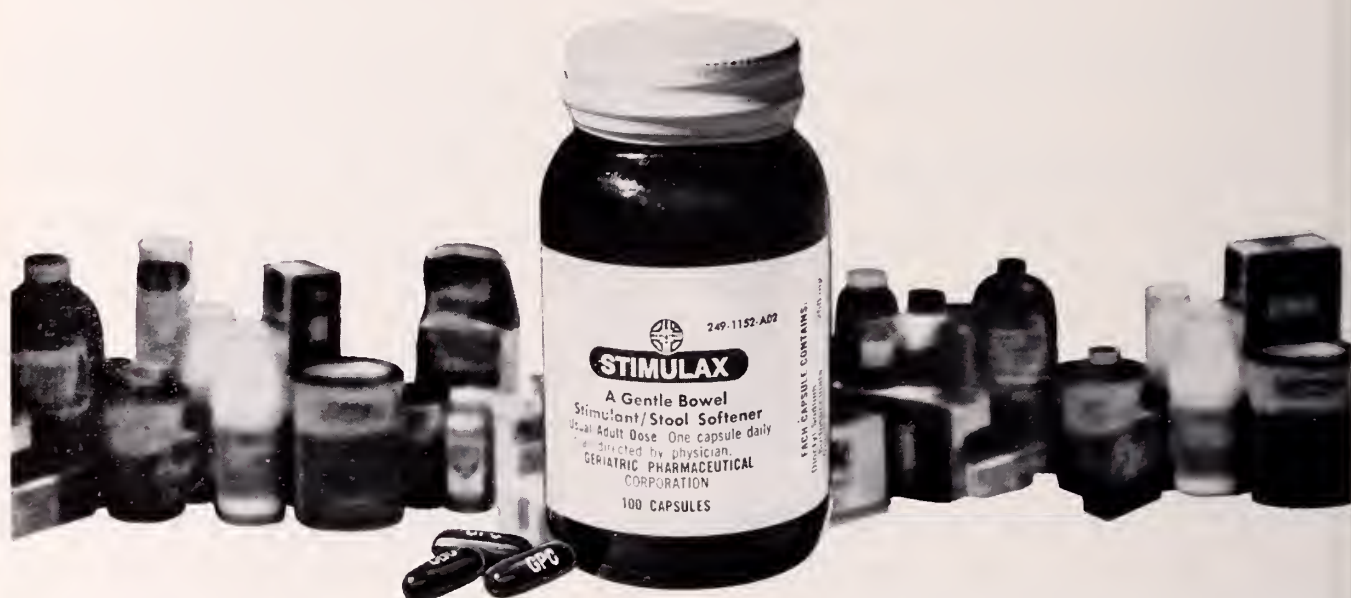
In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

**BACTRIM**™  
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



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## President's Page



### NFL — Pete Rozelle — Russell Roth — AMA

The awesome, infinite tenacles of the federal government have now extended to embrace professional football.

Having shown how it can provide economical and efficient mail service, manage farm programs, control inflation, and otherwise manipulate the free enterprise system by legislation and edict, our government will now assist in yet another endeavor.

Not since the Romans fed Christians to the lions had attendance been so great for stadium-held sporting events. Team owners, concessionaires, stores, restaurants, cab and bus drivers, TV networks and sponsors, and countless other participants in the system had produced a formula that had worked for them and for millions of football fans. The Sunday mayhem, a part of the American culture, had provided entertainment, vicarious release of hostilities, and escape from anxieties. Congress then passed another law.

The merits of the TV blackout are not the subject of discussion. The single point is that an ever-changing formula had evolved to the benefit of all. Quality, service, costs, supply and demand were the controlling elements. Possibly the next step would have been the voluntary lifting of blackouts—but, now we will never know. Our Congress, in its unquestionable wisdom, has spoken. The various participants must adjust.

We, in organized medicine, are not strangers to government intervention. We advised against including those who could take care of themselves in the Medicare program. We predicted this format would result in exorbitant costs. Projections now reveal that the program which they estimated at three billion dollars annually will go to thirty billion dollars by 1980. In an effort to correct their mistake, our legislators have given us PSRO (a four letter word) to stem the rising costs of Medicare and Medicaid. This is another mistake, and two wrongs still don't make a right.

Caspar Weinberger, Secretary of HEW, recently commented that "The real culprit behind rising health costs is the federal government . . . (which), through its policies, has had a major role to play in causing the health care costs to spiral." When ineffective government programs fail miserably, ineffective new programs are added as stop-gap measures. Eventually another monster is created to consume the resources of the constituents.

What ever happened to laissez faire? Isn't it long past time that the federal government returned to the democratic free enterprise system espoused by Thomas Jefferson?

Maybe as a team, Pete Rozelle, Commissioner of the NFL, and Russell Roth, president of the AMA, should take their cases to the President of the United States. He should be told that the government is meddling with the greatest entertainment feature America has ever known, and the finest medical care delivery system the world has ever seen.

A large, stylized handwritten signature in black ink, which appears to read "Russell Roth". The signature is fluid and cursive, with a prominent loop at the end.

# Gantanol (sulfamethoxazole) and the

## 0.1 M.I.C.

### for three hours

Similar elongations occur regardless of antibacterial used.

## 1.0 M.I.C.

### for three hours

Similar midcell defects seen with increased antibacterial concentrations.

## 10 M.I.C.

### for three hours

Similar spheroplast-like forms appear with high concentrations of the antibacterials.



E. coli + sulfamethoxazole



E. coli + tetracycline

## The Scanning Electron Microscope (SEM) reveals the effect

**The *in vitro* experiment.** These SEM photomicrographs were taken as part of a study exploring the effects of various antibacterials with different modes of action on the surface morphology of bacteria. The scanning electron microscope was used because of its ability to show three-dimensional views of organisms, enabling better definition and appreciation of surface morphology.

For this portion of the experiment, *E. coli* were exposed to the following agents: sulfamethoxazole, a chemical drug which acts by interference with para-

aminobenzoic acid utilization; tetracycline, which interferes with intracellular protein synthesis; and cephalothin and ampicillin, which are cell-wall-active drugs.

Strains of *E. coli*, each susceptible to the respective antibacterials, were exposed for 15, 30, 60, 120 and 180 minutes and 18 hours to several concentrations of each agent.

Following the 180-minute or three-hour exposures to the antibacterials at 0.1 M.I.C., 1.0 M.I.C. and 10 M.I.C., photoscans of the *E. coli* were taken. As shown above, regardless of the antibacterial agent used or its mode of action, the changes in surface morphology were remarkably similar... elongation at low drug concentrations, midcell defects at higher



# Three-Dimensional World of SEM



E. coli + cephalothin



E. coli + ampicillin

## of certain antibacterials on bacterial surface morphology

concentrations and ultimate progression to spheroplast-like forms.<sup>1</sup>

**The interpretation.** "At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

**It should be noted that this information represents only *in vitro* research. No clinical significance can be drawn from this study concerning the effective-**

**ness of any of the agents discussed, as it is not possible to extrapolate *in vitro* data to humans. This information is presented to demonstrate the continuing research activities in the area of antibacterials, particularly modes of action and surface morphology.**

<sup>1</sup>Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

<sup>2</sup>*Antimicrob. Agents Chemother.*, 1:164, 1972.

See next two pages for product information.

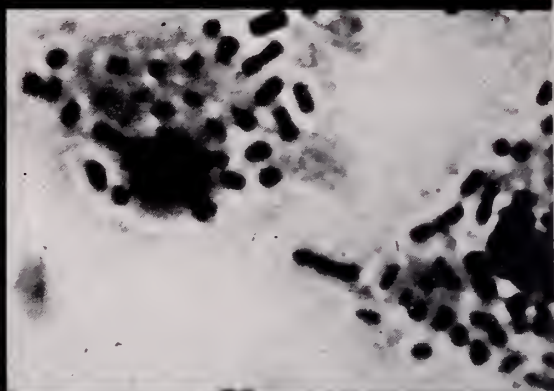


Roche Laboratories  
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Nutley, N.J. 07110

# Observations from



*E. coli*—Fluorescent stain



*Klebsiella* sp.—Stain to define capsular envelope

## ■ Effective control of primary susceptible bacterial offenders

Gantanol® (sulfamethoxazole) is effective against susceptible strains of *E. coli*, the most common cause of urinary tract infections. It is also highly effective against other susceptible gram-negative and gram-positive organisms, usually *Klebsiella-Aerobacter*, *Staph. aureus* and *Proteus mirabilis*.

## ■ Prompt antibacterial blood and urine levels—in from 2 to 3 hours

Antibacterial levels of Gantanol usually appear in blood and urine in from 2 to 3 hours after the initial 2-Gm adult dose. This rapid initiation of effective antibacterial activity enables prompt treatment of certain nonobstructed urinary tract infections and may also help avert possible sequelae.

## ■ Around-the-clock coverage for 14 days

Mounting evidence in current medical literature suggests a minimum of 14 days' continuous therapy for certain urinary tract infections.\* Following the initial 2-Gm adult dosage of Gantanol, each 1-Gm dose provides up to 12 hours of antibacterial activity during the treatment period. When urinary tract infection is more severe, *t.i.d.* (q. 8 h.) dosage schedule may be required. Both regimens provide around-the-clock therapy, important because normal urinary retention during sleep tends to favor bacterial proliferation. It is also convenient for patients not to have to take middle-of-the-night medication.

## ■ Also effective in certain nonobstructed chronic and recurrent urinary tract infection

Nonobstructed urinary tract infections, such as cystitis or pyelonephritis—chronic and/or recurrent—develop more commonly in the elderly and debilitated, and response to Gantanol is often highly satisfactory.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-

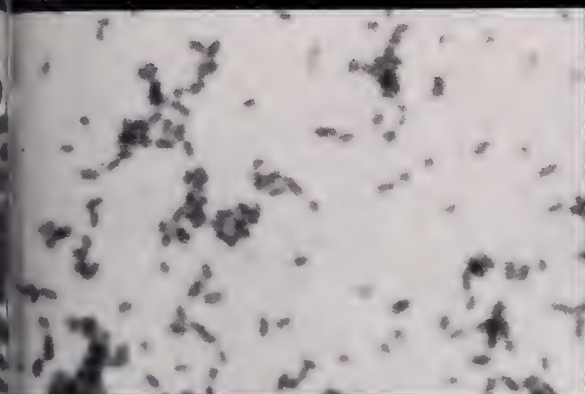
hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

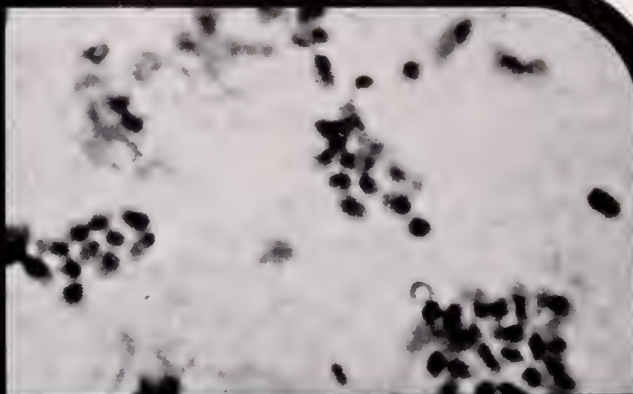
**Adverse Reactions:** Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglo-



# clinical practice



*Enterobacter* sp.—Gram stain showing characteristic gram-negative rod



*Proteus mirabilis*—Flagella stain

## ■ Your option: tablets or suspension

Gantanol Tablets or the pleasant-tasting, cherry-flavored Suspension can provide dependable antibacterial activity to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement usually may be expected to begin within 24 to 48 hours. Usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol is generally well tolerated, with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended during therapy.

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

## Gantanol<sup>®</sup> B.I.D. (sulfamethoxazole) Basic therapy

binemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage:** Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

## Medical News

### A New Medical Series on PBS-TV

Each year one million Americans are stricken for the first time with heart attacks. Nearly half of them die. While heart disease is thought of as a killer of the over-40 group, its lethal effects are felt by all ages: infants with congenital heart malformation; adolescents and young adults with rheumatic heart disease; the middle-aged with angina or a full-fledged coronary; the aged with a "worn-out" heart, often after years of mistreatment. Researchers have identified many pre-conditions of heart disease, including hypertension, fat-rich diets, obesity, lack of exercise, smoking, or a pre-existing genetic problem, but Americans are not yet committed to the concept of prevention vs. cure.

A dramatic indication of this lack of commitment is the rise in the incidence of heart attacks, especially among men in their early 20's and 30's, who suffer "sudden death syndrome"—fatal heart failure without warning—and among women.

Statistics underline the seriousness of the problem and emphasize how little is known about the heart and its mechanism. While progress is being made in surgical techniques, chemotherapy and prosthetic devices, the quality of health care is, at best, spotty. For example, a victim's chance of surviving a heart attack in a major urban area has been estimated as much better than in most of the rest of the United States.

What the medical profession, the individual and the community can do to prevent heart disease and equalize treatment are covered in the first program of a new series on PBS-TV.

Beginning this month—"The Killers"—an hour and a half medical documentary will be presented every 4th Monday evening at 8 p.m. over the following Florida Public Broadcasting Service stations:

WUFT-Ch	5	Gainesville
WJCT-Ch	7	Jacksonville
WPBT-Ch	2	Miami
WMFE-Ch	24	Orlando
WSRE-Ch	23	Pensacola
WFSU-Ch	11	Tallahassee
WEDU-Ch	3	Tampa
WUSF-Ch	16	Tampa
WTHS-Ch	2	Miami (in-school)
WLRN-Ch	17	Miami

Made possible by a grant from the Bristol-Myers Company, "The Killers" is designed to inform the public about methods of prevention, early detection and treatment of the five medical conditions that accounted for 75.7 percent of deaths (1½ million) in the United States last year. Heart Disease, Nov. 19; Inborn Genetic Defects, showing Dec. 17; Pulmonary Disease, appearing Jan. 14; Trauma, for viewing Feb. 11, and cancer, on Mar. 11 are the topics and times.

### 80 Begin Medical Studies

Eighty young men and women, including 11 black students began their medical education as first-year students at the University of Florida College of Medicine in September. It was the largest first-year class in the College's history.

The entering class includes 11 women, three of whom are black. Most of the new students are from Florida, but the states of Alabama, Connecticut, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania, South Carolina, Virginia and West Virginia also are represented. There is also one student from Columbia and two from Nigeria.

### Kidney Donor Program

Thirty hospitals in South Florida are cooperating in a kidney transplant donor program under the sponsorship of the University of Miami School of Medicine.

The program is designed to increase the supply of transplantable organs. As a result of the program, eight victims of chronic kidney disease received transplants during July compared with an average of 2.5 transplants per month for the 12-month period that ended June 30.





**Colic? Diarrhea? Eczema? Asthma?  
Rhinitis? Fretfulness? Fitful Sleep?**

## **Soyalac is often the answer.**

This ailing, wailing syndrome in infants (and older children) is all too familiar. Fortunately, the physician has at his command a trusted ally: milk-free, fibre-free, hypo-allergenic Soyalac.

Soyalac is palatable, readily digested and assimilated. It simulates human milk in appearance, taste, texture. It is complete with vitamins and minerals. It is equally suitable for children and adults allergic to cow's milk.

Through the years Soyalac has proved its value—in promoting growth and development—as attested by extensive clinical data.

**Free samples and literature on request.**

A simple note on your prescription form will do.

Now available in 3 forms:  
Concentrated Liquid,  
Ready-to-Serve, Powdered



a product of  
**LOMA LINDA FOODS**  
MEDICAL PRODUCTS DIVISION  
RIVERSIDE, CALIFORNIA 92505  
Mount Vernon, Ohio 43050, U.S.A.



# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions



## INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

# Chewable Tablets<sup>500 mg</sup> Mintezol<sup>®</sup> (THIABENDAZOLE | MSD)



so easy to take  
everyone in the family  
can keep to the  
regimen you prescribe

include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.  
Supplied: Chewable tablets, containing 500 mg thiabendazole, in boxes of 36, strip packaged, individually foil wrapped; Suspension, containing 500 mg thiabendazole per 5 ml, in bottles of 120 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

# FEEDBACK - from Pearl Street

## Gonorrhea in Florida

Availability of penicillin in the 1940's significantly altered the clinical course of gonorrhea. Within hours after administration signs and symptoms literally disappeared, followed by disappearance of the gonococcus. Effectiveness was so dramatic that rapid control was anticipated. A steady decline did occur, going to a low of 8,867 reported cases in 1962, but since then the increase has been continuous reaching 30,659 in 1971. At that time gonorrhea was declared epidemic in Florida and in the United States. The fact that the disease was getting out of control could not be blamed on penicillin. Resistance had increased, but penicillin is still dramatically effective and continues as the treatment of choice.

Federal funds became available late in 1971 and Florida tooled up for a major attack on the problem. Gonorrhea appeared to be a disease predominantly of the male since nearly three cases were reported for each female case. Careful epidemiologic studies, however, revealed that many females were infected yet showed little or no symptoms and hence were unaware of the infection. Nevertheless these females were serving as a reservoir to infect males who in turn infected additional females.

An intensified control program was initiated in 1972. The main thrust was upon treatment of all symptomatic males and search for asymptomatic females by culturing all those 15-40 years of age with emphasis upon high risk groups: young, lower socioeconomic groups and those in cities exceeding 200,000 population.

A major hurdle that had to be cleared for successful screening was availability of adequate dependable cultures. The Division of Health's Bureau of Laboratories had processed only 42,327 cultures in 1970 and 54,465 in 1971 and program plans called for 266,000 in fiscal year 1972-73. The Bureau of Laboratories increased its services and also offered assistance to private laboratories in terms of training and evaluation.

Cooperation of all health care providers whose services included pelvic examination of females was solicited. The response was most gratifying and the number of cultures taken increased from approximately 5,000 in July 1972 to 37,000 in March 1973. Screening is currently proceeding at a level of over 41,000 per month.

From July 1972 to May 1973 about 220,000 cultures were processed. VD clinics showed 21.3% positive, community health centers averaged 9.3% positive, correction centers 4.7%, private family groups 6%, hospital outpatients 5.6%, health department nonvenereal disease clinics 5.2%, group health centers 4.8%, student health centers 2.7%, private physicians 2.6%, manpower agencies 1.5%, and military hospital inpatients less than 1%.

Health departments have done 50% of testing, private physicians 30%, military 5%, neighborhood health centers 3%, hospitals 6%, student health centers 3%, and all others 2.3%.

The level of screening currently in progress (about 40,000 cultures/month) appears satisfactory if this level can be maintained until symptomatic gonorrhea and the asymptomatic female (and male) reservoirs are reduced to a level where the epidemiologic approach can be applied on a practical basis. The outlook for success in bringing gonorrhea under control may be looked upon as guardedly optimistic.

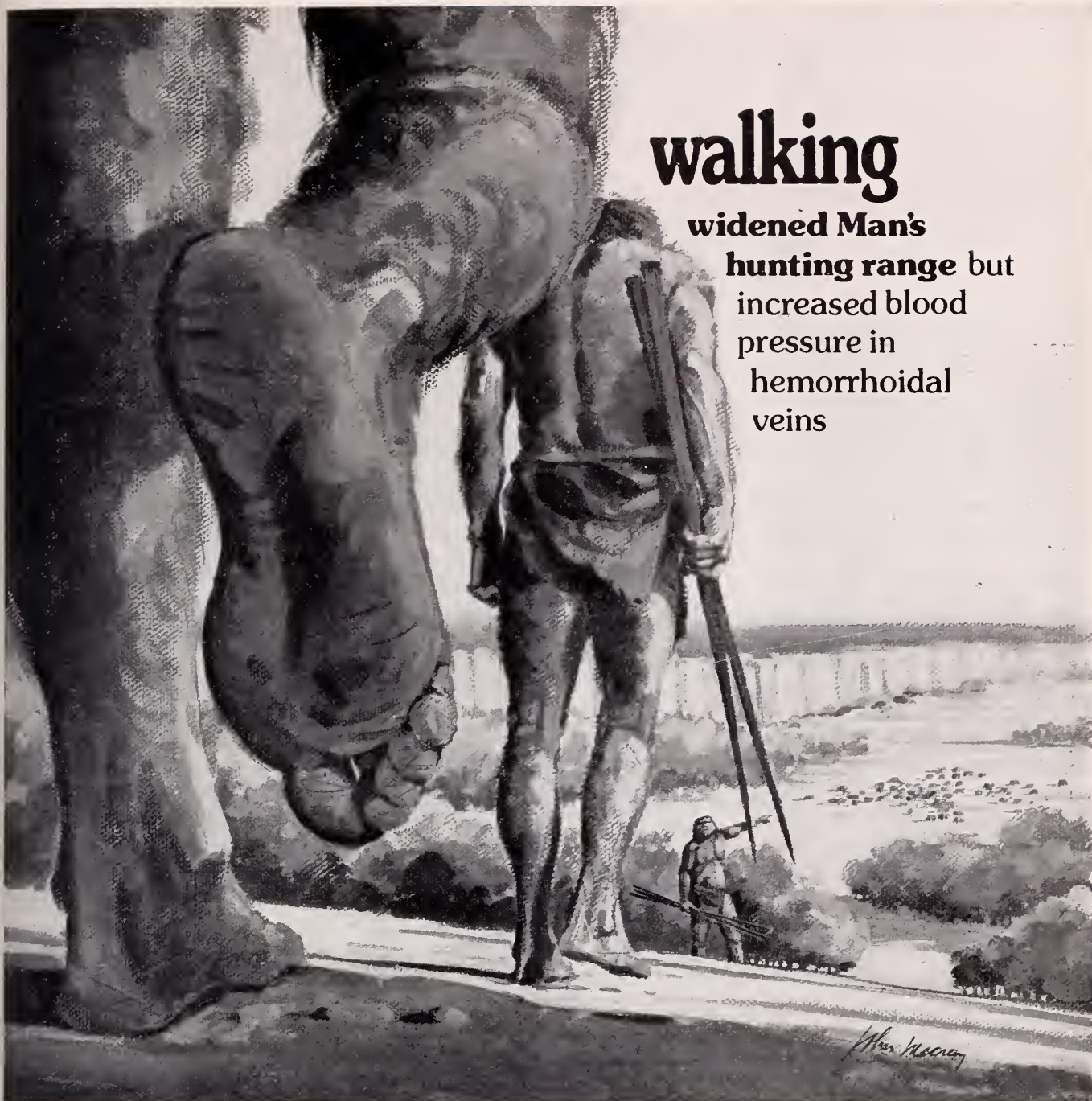
A comparison of the periods July 1972 through March 1973 with the same months of 1971 and 1972 shows a 22% total increase in gonorrhea. The majority of the increase was in females as a result of the screening program.

An examination of data by quarters shows some indication that the rate of increase in male morbidity is decreasing both in health department clinics and private physician offices.

The positivity rate of female cultures by total providers dropped from 11% in July 1972 to 4.5% in April 1973. While this may be largely due to dilution by including in the screening the lower risk population it is nevertheless encouraging. That some favorable progress is being made is further suggested by the drop in ratio of 2.5 male cases to one female in 1971 to only 1.5 male cases to one female case in March 1973. A ratio between males and females of 1:1 should suggest that the female reservoir has been effectively identified.

With all segments of health providers, public and private, cooperating, the battle is underway but the war on venereal disease is far from over. Continued cooperative efforts are essential.





# walking

**widened Man's  
hunting range but  
increased blood  
pressure in  
hemorrhoidal  
veins**

**Precaution**  
Prolonged or excessive  
use of Anusol-HC might  
produce systemic  
corticosteroid effects.

Symptomatic relief should  
not delay definitive  
diagnosis or treatment

**Dosage and Administration**

Anusol-HC: One suppository  
in the morning and one at  
bedtime for 3 to 6 days  
or until the inflammation  
subsides.

Regular Anusol: one  
suppository in the morning,  
one at bedtime, and one  
immediately following each  
evacuation.

## to help ease acute symptoms of **Anusol-HC**<sup>®</sup>

**Hemorrhoidal Suppositories with Hydrocortisone Acetate. On your Rx only!**  
Each suppository contains hydrocortisone acetate 10 mg; bismuth subgallate 2.25%;  
bismuth resorcin compound 1.75%; benzyl benzoate 1.2%; Peruvian balsam 1.8%; zinc  
oxide 11.0%; and boric acid 5.0%; plus the following inactive ingredients: bismuth  
subiodide, calcium phosphate, and coloring in a bland hydrogenated  
vegetable oil base containing cocoa butter.

## for long-term patient comfort **Anusol**<sup>®</sup>

**Suppositories and Ointment** Each suppository or gram of  
ointment contains the active ingredients of an Anusol-HC  
suppository minus the hydrocortisone.

**Warner/Chilcott**



Division,  
Warner Lambert Company  
Morris Plains, New Jersey  
07950

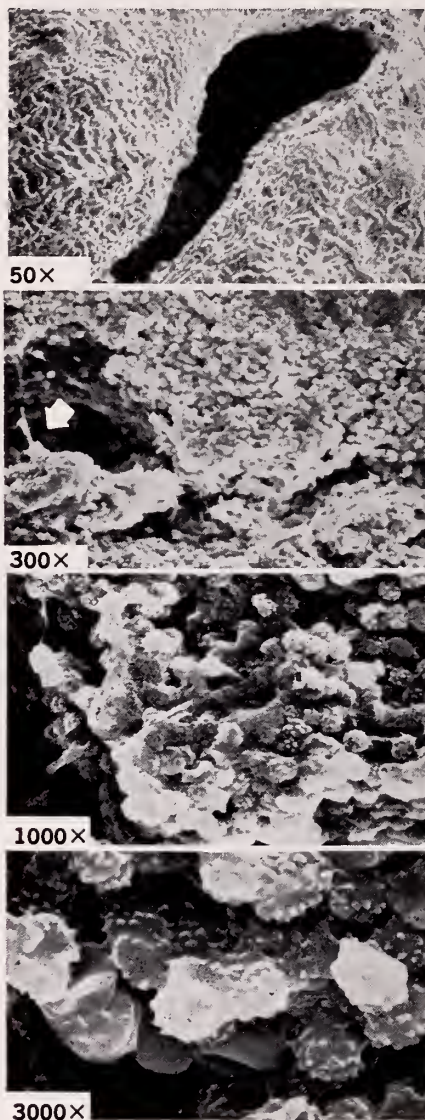
ANGP 35



# Progress in Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50X), a fibrin strand (300X), and a whitish exudate composed of polymorphonuclear leukocytes (1000X and 3000X). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



## A note on the photography:

These photographs were made by the scanning electron microscope, which, like the transmission electron microscope, operates on the basic principle of exposure of tissue to a beam of electrons in a vacuum. With the SEM, electrons bombard the surface of tissue which has been given a fine coating of gold. The electrons reflect off the tissue onto a television screen, and the resulting photograph shows a three-dimensional effect. The tissue sections need not be ultrathin, so there is a minimum of handling and distortion.

Just as much an instrument of progress and just as helpful in its way has been Gantrisin (sulfisoxazole) Roche, developed and introduced a generation ago. However, there's been no generation gap over its continuing usefulness. In fact, Gantrisin, with so many years of clinical experience behind it, is still one of the most valuable drugs we have for the treatment of non-obstructed cystitis, pyelitis or pyelonephritis due to susceptible organisms such as *E. coli*. Specifically, Gantrisin provides your patient with certain important therapeutic advantages:

**References:** 1. Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther.*, 12:525, 1971. 2. Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc.*, 44:318, 1969. 3. Hibbard, L. T., in Bulger, M. J., et al.: *Patient Care*, 1:(3) 47, 1967. 4. Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol.*, 102:249, 1969. 5. House, T. E., et al.: *Obstet. Gynecol.*, 34:670, 1969. 6. Lampe, W. T.: *J. Am. Geriatr. Soc.*, 16:798, 1968. 7. Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res.*, 13:286, 1971. 8. Normand, I. C. S.: *Practitioner*, 204:91, 1970. 9. Pryles, C. V.: *Med. Clin. North Am.*, 54:1077, 1970. 10. Seneca, H.; Peer, P., and Warren, B.: *J. Urol.*, 99:337, 1968. 11. Trafton, H. M., and Lind, H. E.: *J. Urol.*, 101:392, 1969. 12. Cohen, M.: *Pediatrics*, 50:271, 1972.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

**IMPORTANT NOTE:** *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml;

measure levels as variations may occur.

**Contraindications:** Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

**Warnings:** Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic

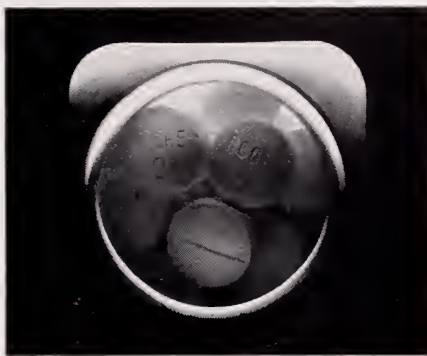


# acute cystitis:

## Treatment

**high urinary levels** As a urinary antibacterial, Gantrisin (sulfisoxazole) offers your patients important advantages. Therapeutic urinary and plasma concentrations are usually reached in from 2 to 3 hours and can be maintained on the recommended 4 to 8 Gm/day dosage schedule that's convenient for almost all patients.

**generally good tolerance** Gantrisin causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Hence, Gantrisin may usually be given even for extended periods when treating chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms. (See important Note in summary of prod-



uct information.) Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

**high solubility** Gantrisin (sulfisoxazole) Roche is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in

60 minutes; therapeutic levels are usually reached in from 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

**economy** Average cost of therapy is still only about 6½¢ per tablet.

**total therapy: 14 days** Recent evidence in the medical literature suggests that therapy in acute non-obstructed urinary tract infections should be continued for 10 to 14 days even if patients become asymptomatic in 2 or 3 days, as they often do.<sup>1-11</sup> However, one investigator, evaluating a 5-year study of sulfisoxazole used to treat urinary tract infection in 368 girls, found no advantage in continuing therapy more than two weeks *for a first infection*.<sup>12</sup>

**For acute, chronic or recurrent nonobstructed cystitis, pyelitis, or pyelonephritis due to susceptible organisms...**

begin with  
**Gantrisin<sup>®</sup>**  
**sulfisoxazole/Roche<sup>®</sup>**

**Usual adult dosage:** 4 to 8 tablets *stat*  
2 to 4 tablets *q.i.d.*

examination should be performed frequently.

**precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* granulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* urticaria, erythema multiforme (Stevens-Johnson

syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due

to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

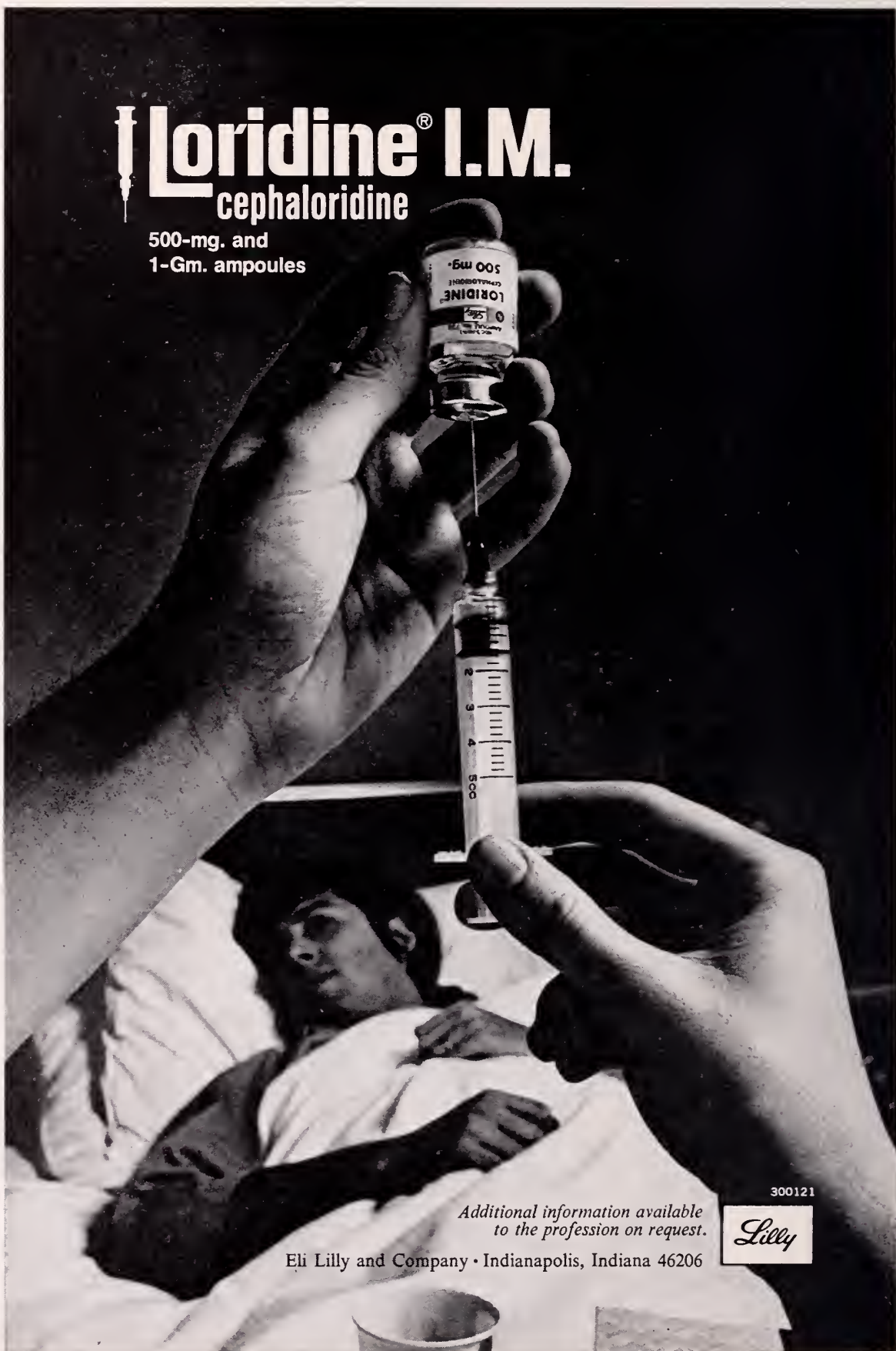
**Supplied:** Tablets containing 0.5 Gm sulfisoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Loridine<sup>®</sup> I.M. cephaloridine

500-mg. and  
1-Gm. ampoules



Additional information available  
to the profession on request.

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*Lilly*





## Chemotherapy of Parasitic Diseases Commonly Seen in the United States

(Part II)

LEONARD WILLIAM SCHEIBEL, Sc.D., M.D.

**Abstract:** Parasitic diseases which occur most frequently in the United States are caused by only a very few members of three major phyla, each sensitive to specific drugs. Correct diagnosis followed by choice of the proper drug known to be effective against the particular parasite will result in high cure rates with minimum side effects. The first part of this article was published in last month's issue of the Journal.

### Intestinal Cestodes (Flatworms)

*Taenia saginata*, *T. solium*, *Diphyllobothrium latum*, *Hymenolepis nana*—The high level of efficiency coupled with a considerable margin of safety and freedom from side effects gained preference for niclosamide (available from Parasitic Disease Drug Service, Atlanta) over the older tapeworm treatments.<sup>31</sup> It is available for clinical use to any licensed physician with proof of diagnosis for *T. saginata*, *H. nana*, *H. diminuta*, *D. latum*, but only after therapeutic failure with quinacrine in *T. solium* infections. Two tablets of 500 mg niclosamide are thoroughly chewed, followed in one hour by another 2 tablets. Children less than 10 years of age receive half the adult dose and very young children, one fourth the dose.

Some clinicians follow this in 2-3 hours with a saline purge and even precede the first dose with a purge by 3 hours. This is most important in *T. solium* infections since the drug causes digestion of worm segments and this combined with emesis (reverse peristalsis) may result in cystercosis. Even though this is a theoretical possibility, there has been no evidence of this occurring so far in the use of this drug. Toxicity is almost nonexistent except very rare gastrointestinal upset. The drug is tasteless and odorless but is compounded in vanilla-flavored tablets. Recent cure rates have averaged 98-100%.<sup>31-33</sup>

Another drug almost as good as niclosamide is dichlorophen but it has a phenolic odor and taste and self-limited gastrointestinal upsets may accompany administrations. Dosage is 6-9 gm for adults or 2-4 gm in children and in a single dose gives 80% cures. Neither niclosamide or dichlorophen are absorbed from the gut. Both drugs are considered to be the least toxic and most effective agents used in the treatment of tapeworm infections<sup>34</sup> but partial digestion of the worm precludes finding the scolex in the feces posttreatment. Therefore, assessment of cure should be done by a stool check three months after treating the patient.

Intubation and duodenal instillation of 0.8-1 gm quinacrine hydrochloride suspended in 20 cc H<sub>2</sub>O may give 80-90% cures. Children 20-30 kg in weight receive 0.4 gm total dose and those weighing 30-50 kg receive 0.6 gm total dose.<sup>35-36</sup> Poor cure rates, especially in children's dosages,

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coupled with transient nausea, vomiting, dizziness and the necessity of passing a tube make this therapeutic approach less desirable.

The ancient extract from the male fern plant dating from the time of Theophrastos (371-286 B.C.) is still used. The active component, desapiadin, a phloroglucinol compound, in a dose of 200 mg taken up with 30 gm castor oil was 87.8% effective and 400 mg results in 91% cure rates but this drug unfortunately is accompanied by gastrointestinal toxicity.<sup>37</sup>

### Trematode (Fluke) Infections

*Schistosoma mansoni*, *S. japonicum* and *S. haematobium* (schistosomiasis)—Niridazole, a nitrothiazole, like every other active substance used in the treatment of this disease gives rise to side effects, but the drug is considered to be superior to the classical schistosomicidal agents. It is available from the Parasitic Disease Drug Service, Atlanta, for investigational purposes to any licensed physician with proof of viability of eggs and species diagnosis. Doses of 20-25 mg/kg daily for 4-10 days in *S. haematobium* and 20-40 mg/kg daily for 5-15 days in *S. mansoni* have yielded excellent results (cure rates up to 100% in *S. haematobium* infections).<sup>38</sup> In *S. japonicum* infections treatment with 15-25 mg/kg daily for 5-10 days produced less good results.<sup>39</sup> Side effects include decreased spermatogenesis in the human male in 50% of the cases, headaches, nausea, anorexia, abdominal pain, vomiting, dizziness, and occasionally convulsions and psychic disturbances. These can be decreased by dividing the 25 mg/kg/day dose into 3 aliquots and even accompanying it with diallylbarbituric acid (Dial) 50 mg twice a day for 7 days.<sup>40</sup> Niridazole is contraindicated in hepatosplenic disease (since this results in a high plasma level of the drug), or in patients with a history of neuropsychiatric disease. It does have the advantage of being an oral medication which makes it preferable to antimony sodium dimercaptosuccinate, which must be injected.

### Protozoa

#### BLOOD

*Plasmodium falciparum*, *P. vivax*, *P. ovale*, *P. malariae* (malaria)—The treatment of an acute attack of malaria caused by species other than chloroquine resistant *P. falciparum* is rather uncomplicated and can be accomplished by use of a blood schizonticide such as the 4-aminoquinoline drug, chloroquine. An initial loading dose of 600

mg (base) chloroquine phosphate or chloroquine sulphate (or 1 gm salt) is followed by an additional 300 mg (base) after 6 hours and doses of 300 mg (base) daily on each of 2 consecutive days not to exceed 1500 mg of base in 3 days. If coma or vomiting precludes oral administration, chloroquine hydrochloride may be administered in a dose equivalent to 200 mg base immediately followed in 6 hours by another dose not to exceed 800 mg base equivalent in the first 24 hours. Dosages in children should not exceed 5 mg/kg body weight.

Chloroquine must be combined with an 8-aminoquinoline such as primaquine phosphate to achieve a radical cure in *P. vivax*, *P. ovale*, *P. malariae* infections. Patients should first be tested for glucose-6-phosphate dehydrogenase deficiency to avoid the possibility of hemolysis in susceptible individuals. This drug is given to destroy the exoerythrocytic forms of the parasites which persist in the liver and from which the parasites causing relapse emerge. If the enzymic deficiency cannot be tested, it has been suggested to start the patient at a dose one quarter of that normally administered and closely observe the patient. Recommended dosage is 15 mg primaquine base (one 25.4 mg tablet of salt) daily for 14 days.

The emergence of chloroquine resistant strains of *P. falciparum* requires an alternate treatment regimen which is referred to by some as the "blunderbuss" approach. This is based on the observations in 1955 that pyrimethamine, a diamino-pyrimidine, potentiates the antimalarial activity of sulphonamides and sulphones<sup>41</sup> but only recently has it been put to practical use. In Viet Nam, studies indicate 98% radical cures when these two drugs are combined with the rapid acting blood schizonticide, quinine. One regimen consists of 1 to 1.5 gm of the long acting sulfonamide, sulphadoxine (sulphormethoxine) in a single oral dose with 50-75 mg pyrimethamine once a week for 2 weeks, combined with 600 mg quinine three times a day for a week.<sup>42</sup> The American Army in southeast Asia had good results with 600 mg quinine three times a day for 10 days, 25 mg pyrimethamine twice a day for 3 days and either dapsone, 25 mg once a day for 28 days or sulfadiazine, one gram per day for 10 days. Pernicious or cerebral malaria should be treated with intravenous quinine dihydrochloride 600 mg (10% less of base) in a continuous infusion over 8 hours or until the patient is able to tolerate oral medications.



# DRUGS OF CHOICE FOR PARASITIC INFECTIONS

Disease/Pathogen	Drug of Choice	Cure Rate	Dose	Side Effects
Cestodes:				
Tapeworms	Niclosamide	98-100%	Adults—1 gm thoroughly chewed followed in 1 hour by 1 gm Children—less than 10 receive 1/2 dose, very young 1/4 dose Saline purge 2-3 hours before and after in <i>T. solium</i> infections	rare GI upset
Trematodes:				
<i>Schistosoma haematobium</i>	Nitridazole	100%	20-25 mg/kg QD for 4-10 days	decreased spermatogenesis headaches
<i>S. mansoni</i>	Nitridazole	—	20-40 mg/kg QD for 5-15 days	nausea
<i>S. japonicum</i>	Nitridazole	less good	15-25 mg/kg QD for 5-10 days	anorexia abdominal pain vomiting dizziness occasional convulsions
Protozoa:				
<i>Plasmodium falciparum</i>	Chloroquine		600 mg chloroquine phosphate or sulfate followed in 6 hours by 300 mg, and 300 mg QD for 2 consecutive days (not to exceed 1.5 gm in 3 days)	gas, rointestinal upset pruritus transient headaches visual disturbances
<i>P. vivax</i> <i>P. ovale</i> <i>P. malariae</i>	Chloroquine and Primaquine		15 mg primaquine QD for 14 days	abdominal distress rare anemia cyanosis
Drug Resistant <i>Plasmodium falciparum</i>	Sulphormethoxine	98%	1-1.5 gm once/week for 2 weeks	anemia, rash
	Pyrimethamine		50-75 mg once/week for 2 weeks	rarely anemia
	Quinine		600 mg orally TID for a week	tinnitus visual disturbances nausea and vomiting
<i>Entamoeba histolytica</i>	Metronidazole	90%	750-800 mg orally TID for 5-10 days	nausea vomiting diarrhea cramping transient leukopenia
<i>Giardia</i> sp.	Metronidazole	92%	250 mg orally TID for 5-10 days	refer above
<i>Trichomonas vaginalis</i>	Metronidazole	80% or better	250 mg orally TID for 10 days or 250 mg orally BID and 500 mg QD inserted vaginally	refer above
Amebic meningoencephalitis	Amphotericin B	—	0.25 mg/kg IV over 4 hrs. increasing to 0.75 mg/kg after 4 days for 10 days for a total dose of 6.5 gm/kg	decreased renal function and failure vomiting chills fever anemia

## INTESTINAL

*Entamoeba histolytica* (amebic dysentery) — It is generally agreed that metronidazole, a nitroimidazole, is the drug of choice for amebiasis.<sup>43</sup> It is effective in both curing the amebic liver abscesses and eradicating the parasite from the bowel at a dose of 750-800 mg given three times a day for 5-10 days achieving a 92% cure rate.<sup>44,45</sup> Sigmoidoscopic studies have indicated that stools have been negative and ulcers healed by the end of the fifth day of treatment.<sup>46</sup> Erythromycin stearate or niridazole both result in lower cure rates and a higher incidence of side effects. Metronidazole produces relatively few changes electrocardiographically indicating it might be the best choice for high risk cardiac patients in contrast to emetine, dehydroemetine, and niridazole.<sup>47</sup> Side effects at this dose are few but metronidazole may cause nausea, a bitter taste, vomiting, diarrhea, flatulence, cramping or transient leukopenia.

*Giardia lamblia*, *G. intestinalis* (giardiasis) — Metronidazole has also been shown to be the drug of choice for this flagellated intestinal protozoan which resides in the duodenum giving 92% cure rates at a dose of 250 mg three times a day for 10 days.<sup>48</sup>

## GENITAL URINARY

*Trichomonas vaginalis* (urogenital trichomoniasis) — Studies indicate this flagellated protozoan may be present in 5-80% of women who are still in childbearing age and their sexual partners.<sup>49</sup> This parasite causes urethritis, balanitis, epididymitis, and prostatitis in the male. Both

partners should, therefore, be treated simultaneously to prevent one from being a reservoir to the other for reinfection. Most infections will respond to metronidazole in an oral dose of 250 mg three times a day for 10 days. Severe vulvovaginitis infections may require 250 mg orally twice a day accompanied by 500 mg inserted vaginally each day. Cures are 80% or better in a single dose.<sup>36</sup>

## CENTRAL NERVOUS SYSTEM

*Acanthamoeba*, *Naegleria*, *Hartmannella* (amebic meningoencephalitis) — Recent deaths in the states of Virginia, Texas and Florida as well as Czechoslovakia, Britain, Belgium and Australia focused attention on this free living soil amebae which presumably enters the frontal lobes of the CNS via the nasal membrane and cribriform plate. Infection frequently is acquired by swimming in freshwater lakes. Broad antibiotic coverage usually given to meningitis cases (sulfonamides, chloramphenicol, cristicillin, penicillin, oxytetracycline HCl and streptomycin) has proven inefficient for the most part and death has been the usual outcome. Indications are that amphotericin B is amoebicidal in vitro as well as in animal experiments and it has prolonged the life of at least two patients. Dosages such as 0.25 mg/kg IV over 4 hours increasing to 0.75 mg/kg after 4 days for a total of 10 days for a total of 6.5 gm/kg have been credited with contributing to the survival of several children.<sup>50</sup>

References are available upon request from the author.

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# Vasectomy

## Review of 579 Operations

FRANK RODRIGUEZ, M.D. AND CURTIS M. PHILLIPS, M.D.

**Abstract:** Continuing population growth, changing socioeconomic conditions, awareness of potential harmful side effects of the pill and the fact it is a simpler procedure and less expensive than tubal ligations has established vasectomy as an important method of birth control and family planning in the United States. The Association for Voluntary Sterilization, Inc., estimates that 750,000 vasectomies and 250,000 tubal ligations were performed in the United States in 1970 and that approximately 3 million Americans have had sterilization operations.

We are presenting a review of 579 consecutive vasectomies performed over a two year period from January 1971 through January 1973. The age of the patients ranged from 20 years to 57 years and throughout this period the average age was 32.02 years. The average number of children per couple was 2.33.

### Procedure

The patient is given a mild tranquilizer (10 mg. Librium) and the genitalia is prepared with pHisoHex and aqueous Zephiran. The scrotum is then shaved and draped. The scrotal vas is identified by palpation high in the scrotum and is fixed against the scrotal wall with the index and middle fingers behind the thumb in front which simultaneously separates the cord from the vas. In this manner, the vas not only is palpated but can be seen bulging under the scrotum. Approximately 3 cc of 1% Carbocaine solution is injected into the skin directly above and around the vas. A 1 cm skin incision is then made, the underlying areolar tissue is spread with iris scissors down to the vas. The vas is grasped with an Allis clamp and delivered through the incision. The fascia surrounding the vas is incised with a scalpel,

the bulging vas is grasped with a forcep. At present a section of vas approximately 2 cm to 3 cm is excised and sent for histologic verification. Both ends of the vas are crushed and ligated with 4-0 Tevdek and the skin is closed with 2 to 3 sutures of 3-0 plain catgut. This procedure is performed bilaterally and total operative time is 10 to 15 minutes. All our vasectomies have been office procedures.

The patient is given a mild analgesic (Darvon Compound 65) and advised to rest for several hours at home with the intermittent use of an ice pack that evening. The following day the patient is told to take warm sitz baths as needed for discomfort. A scrotal support is advised as well as the avoidance of vigorous exertion for one week, at which time the patient is examined. A sperm count is done in two months postvasectomy. If this is negative he is allowed to discontinue contraceptive methods. We advise a repeat sperm count six months postvasectomy and a yearly one thereafter to continue to reaffirm sterility.

### Results

Of the 579 vasectomies performed, 101 patients failed to return for follow-up including sperm count, therefore, 17.4% of the patients were never heard of or seen again. The following data is based on the remaining 478 patients (Table 1), morbidity was 2.69%. We considered morbidity, hematomas, granuloma, swelling and epididymitis (Table 2). These conditions required specific treatment such as antibiotics, incisions and drainage.

In eight weeks, 90% of our patients had negative sperm counts. Negative counts were obtained in 92.70% after ten weeks. We considered a sperm count to be negative when seminal fluid was free of live or dead sperm.

There were three patients who had repeated vasectomies because of continued positive sperm counts. Of these patients, one had 10-15 motile sperm per HPF after one year. The other

This study was performed in cooperation with the Baptist Hospital of Jacksonville and the Planned Parenthood Clinic of Jacksonville. Private patients have been included in this series.

TABLE 1. RESULTS ON 478 PATIENTS.\*

No. Pts.	Av. Age	Av. # Children	Av. length of vas excised	% Neg. Sperm Count		% Spon. Recana- lization	% Morbidity
				8 wks.	10 wks.		
579	32.03	2.33	0.7 cm	90	92.70	0.20	2.69

\*101 patients or 17.4% failed to return for follow-up examination and sperm count.

TABLE 2.

HEMATOMA	0.83%
GRANULOMA	0.41%
SWELLING	0.83%
EPIDIDYMITIS	0.62%

had four motile sperm per HPF after five months. In the latter, recanalization was demonstrated histologically. The recanalization incidence was 0.23%. The third patient continued to have many nonmotile sperm per HPF four months post-vasectomy. Three pregnancies were reported, the first one seven months postvasectomy at which time the husband had 40-45 motile sperm per HPF. The patient was redone but no recanalization was demonstrated although it must have occurred. The second patient's wife became pregnant one year after vasectomy at which time the husband proved to have two motile sperm per HPF. The third reported pregnancy was one year postvasectomy, the husband having had a negative sperm count six months postvasectomy and went on to refuse further sperm counts even in view of the pregnancy. These three vasectomies resulted in a 0.62% of probable recanalization and pregnancies.

#### Discussion

We believe that vasectomy, once it has been decided upon, must be regarded as a permanent procedure with respect to the possibilities of future vasectomy. Therefore, we have revised our method by excising at least 3 cm of vas bilaterally. As an extra precaution we recommend a six month sperm count and a yearly one thereafter, to reaffirm sterility periodically. In our opinion, a sperm count should be considered negative when there is complete absence of sperm,

dead or alive. Due to the fact that short of castration, sterility cannot be guaranteed, the possibility of recanalization must be explained to the patient prior to a vasectomy. The six months and yearly sperm counts must be advised as a precautionary measure.

#### Summary

We have reported a total of 579 vasectomies performed in a two year period with 478 patients having been followed. Our morbidity was 2.69% and spontaneous recanalization was demonstrated histologically in 0.2%. Probable spontaneous recanalization was 0.62% which was also our pregnancy rate.

We believe that our technique is efficient and relatively simple in the proper hands. With the increase in the length of vas excised to 2 cm to 3 cm, we expect our results to improve in the future.

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# Red Tide

## Its Public Health Implications

STANLEY I. MUSIC, M.D., JAMES T. HOWELL, M.D. AND C. L. BRUMBACK, M.D.

**Abstract:** A biological review is presented identifying the marine microorganisms responsible for red tide and the natural conditions that lead to their rapid proliferation. The toxic effects, on both marine life and humans, are enumerated. A rather unique medical and public health problem related to the red tide in the coastal waters of southeast Florida is reported.

Periodically in various parts of the world there occurs a phenomenon known as "red tide." This affects certain coastal areas of the United States causing fish kills and sometimes involving human beings who ingest or come in contact with the toxin. Since there are public health implications of this condition, physicians have an interest in it.

Among the many thousand kinds of marine microorganisms which make up phytoplankton are about 1,000 species of dinoflagellates. These are flagellated protozoans belonging to the order Mastigophora. Episodically, when conditions of tide, temperature, salinity, and nutrient are favorable, certain dinoflagellates are capable of reproducing extraordinarily fast, rapidly increasing beyond their normal populations. At times the organisms may be so abundant as to actually discolor the water, giving it a reddish tint. This has been referred to as a red tide. Red tides may be viewed as natural phenomena which have been documented throughout recorded history in virtually all parts of the world.<sup>1</sup>

Three major types of organisms produce red tide in or near coastal waters of the United States: *Gonyaulax catenella*, *Gonyaulax tamarensis*, and *Gymnodinium breve*. *G. catenella* is the prominent cause in the northwest Pacific coast area (Washington and Oregon), *G. tamarensis*

in the northeast Atlantic coast area (Nova Scotia, New Brunswick, Maine through Massachusetts), and *G. breve* off the west coast of Florida in the Gulf of Mexico with occasional intrusions into the Atlantic coast area of Florida.

Red tides due to *gonyaulax* and *gymnodinium* species have public health aspects which may be conveniently discussed together for both *gonyaulax* species (as their effects are similar), and separately for *G. breve*.

### Gonyaulax Red Tides

*Gonyaulax* red tides have long been associated with paralytic shellfish poisoning. Paralytic shellfish poison (PSP) is a heat-stable neurotoxin synthesized by some *gonyaulax* species and can accumulate in the tissues of shellfish that selectively feed upon them. It is one of the most potent non-protein poisons known, being approximately 50 times stronger than curare. Severe symptoms have occurred with ingestion of as little as 124 micrograms of toxin and death has resulted from the ingestion of 456 micrograms. There are individual differences in tolerance to the poison. Symptoms of poisoning usually develop within 30 minutes of ingestion of the toxic shellfish. Initially there is slight tingling, numbness or burning sensation of the lips, gums, tongue and face, followed by paresthesia and muscle weakness, gradually involving the neck, arms and legs that may progress to complete paralysis of the extremities. Severe poisoning is followed by ataxia, general motor incoordination, respiratory paralysis and death. Patients who survive the first 12 hours generally recover rapidly without any permanent residual effects. Treatment is primarily symptomatic since there is no specific antidote. Evacuation of the stomach may help prevent further absorption of PSP. Shellfish which contain amounts of PSP toxic to humans appear normal in every way.

Cooking does not appreciably destroy the toxin. In September 1972 Massachusetts declared a public health emergency as a result of a *G. tamarensis* red tide with 26 confirmed cases of paralytic shellfish poisoning. Two were classified as severe because respiratory assistance was required. Marketing, exporting and serving of shellfish were prohibited throughout the state and existing stock of shellfish were confiscated. Mussels, soft-shelled clams and scallops were more heavily contaminated. Quahogs and oysters were not affected to any great degree.<sup>2</sup>

### *G. breve* Red Tides

*G. breve* also elaborates a neurotoxin, referred to as G.B. toxin, but it is much less potent than PSP for man. However, unlike gonyaulax species, gymnodinium (as its name implies) is an unarmored or "naked" organism. It does not possess the hard shell which gonyaulax species display. This renders it a very fragile organism and one which is subjected to break-up in areas of heavy wind or surf when the organism is buffeted by severe wave action at or near the surface. Thus, the toxin may be released into the water, which does not usually occur with gonyaulax species. The presence of large amounts of toxin in waters where a bloom of *G. breve* has occurred is responsible for respiratory paralysis in fish resulting in the massive fish kills associated with gymnodinium red tides. Occasionally, under circumstances of very heavy concentration, shellfish may become toxic to man because of ingested *G. breve* organisms. However, this is a rare circumstance and instances of human *G. breve* toxin disease are rare indeed. Moreover, because of the significantly lower toxicity, death from ingestion of this toxin cannot be easily documented, whereas death from PSP toxin was recognized by American Indians before the arrival of European explorers. Most of Florida's problems with *G. breve* red tides occur in the Gulf coast area and are related to the massive fish kills with resultant piles of dead fish on Gulf coast beaches. This is much more of a nuisance than a health hazard. As indicated earlier, only a few instances of disease as a result of the ingestion of toxic shellfish from this source have been recorded.

In the November 1972 red tide in Palm Beach County, an unusual set of circumstances led to a unique phenomenon on the southeast coast of Florida. Apparently, a red tide had occurred earlier in the Gulf coast area southwest of Ft.

Myers and organisms were carried into the gulf stream around and through the Florida Keys by currents existent at the time. These organisms then swept up the east coast past Miami, Ft. Lauderdale and Palm Beach where a significant portion were carried southward again by an unusual strong southerly shear current flowing between the shoreline and the gulfstream. Whatever the specific requirements of *G. breve* for rapid multiplication are, these were apparently met at this time along the Atlantic coast of Palm Beach County. An active bloom of *G. breve* occurred along with a fish kill. Also, a strong constant easterly wind was blowing creating a high energy beach situation. Beginning November 8, the Palm Beach County Health Department and other public agencies in the county began to receive complaints of eye and upper respiratory irritation from residents and visitors. The complaints came from the seashore mainly involving people on the beach (swimmers, workmen, lifeguards) and people who lived in homes at or very near the beach, widely scattered over portions of the eastern edge of Palm Beach County. A syndrome of acute eye irritation and respiratory distress has been noted in the past on the west coast of Florida in association with fish kills and with *G. breve* red tides. It was on this basis that the Palm Beach County Health Department made its "epidemiologic diagnosis" of a red tide, since this is the only known phenomenon which could account for the distribution of cases and the particular symptoms involved. Subsequently, a *G. breve* red tide was confirmed.

People of all ages and both sexes were affected equally. People living in homes with open windows along the beach awakened to find themselves suffering from eye and nose irritation. People who came to the beach remained asymptomatic until they left their cars and walked on the beach. The symptoms were usually quite sudden in onset, with profuse watering of the eyes and a burning sensation in the conjunctival area, severe, usually nonproductive cough, and burning of the nose with copious rhinorrhea. People who could not tolerate these symptoms and who left the beach area immediately did experience a very rapid return to asymptomatic normality. Others who did not leave the beach immediately because of work or similar restrictions noted no progression of the symptoms but did have some lingering effects later when they left the beach area. People living in homes near the beach with open windows who closed these windows and turned on their air



conditioners noted that their symptoms disappeared. Those who got into their cars and turned on the air conditioning also noted the disappearance of symptoms. There were no complaints from people in boats in the offshore area. People who used fishing piers experienced symptoms while getting out of their cars and walking on the beach, but had no symptoms while at the end of the pier beyond the surf. They could stand there and watch other fishermen further in or swimmers and lifeguards on the beach suffering and coughing, but they remained asymptomatic. However, when they went back on the beach they also suffered a recurrence of the same symptoms.

The irritant which caused these symptoms occurs in droplets as an aerosol and does not act as a gas. *G. breve* is easily broken up on a high energy beach. Whether the conjunctival and re-

spiratory irritant released is identical to the toxin remains to be determined. However, it is apparent that whenever *G. breve* is present in sufficient concentrations to cause fish kill (250,000 or more organisms per liter of sea water) an exposure to ocean spray containing *G. breve* organisms may cause the syndrome described. This particular situation in Palm Beach County lasted only a few days—as long as the easterly wind was blowing. As soon as the wind changed direction no cases of eye or upper respiratory irritation syndrome were noted. There were no lasting ill effects of this episode.

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## Rabies

Human cases of rabies relate primarily to wildlife. Any bite constitutes some risk. Medically the physician is prepared for this emergency but lacking are reliable factors to help him decide whether definitive treatment is indicated when the patient presents himself. The physician considers whether the bite was provoked or unprovoked. Species of the animal is important. The wild carnivores and bats, mainly carnivores, transmit the virus to man; rodents seldom.

In immunization and treatment the physician has a choice in procedures and to some extent in vaccines. Antigenicity of the duck embryo vaccine is sufficient to pass the minimum potency test. It has allergenic components but should be considered in preexposure immunization of the high risk patient. Immediate postexposure treatment consists of local wound care. If the animal is rabid, administration of equine serum and antirabies vaccine must be considered. Medically and legally it cannot be ruled out regardless of the interval between exposure and treatment.

The equine serum and duck embryo vaccine present some risk for the patient. No deaths have been reported but an allergenic-type reaction may result, particularly from the latter. The reaction

may be anticipated and the patient started on antihistamines.

Another factor must be considered in providing care—professional liability. A jury will find it difficult to understand that the vaccine was not administered because the doctor considered it unnecessary. Because of the threat of liability, there is no question that patients are being overtreated.

Control of rabies originates at the community level. A single dose of vaccine in an adult dog provides protection for three years. As for wildlife, the only measure appears to be selective population reduction.

This series summarizes proceedings of the Communicable Disease Conference arranged by the Florida Medical Association's Committee on Public Health and the Environment and cosponsored by the Association and the Division of Health, Florida Department of Health and Rehabilitative Services.

Program discussants of Rabies included William F. Hill Jr., M.D., Winter Haven, Director, Polk County Health Department; Keith Sikes, D.V.M., Atlanta, Veterinary Director, Office of Veterinary Public Health Services, Center for Disease Control, and William R. Mulford, M.D., Green Cove Springs.

# Anti-Inflammatory Steroids

## A Review

HOMER KNIZLEY JR., M.D.  
AND MARVIN C. MENGEL, M.D.

**Abstract:** Glucocorticoids are potent therapeutic agents for a number of diverse diseases, but their use is associated with many undesirable effects. Investigators have attempted to minimize these adverse effects by chemically altering the structure of cortisone acetate, the first drug that was available for clinical use. The chemical alterations have resulted in drugs that differ in glucocorticoid potency, degree of sodium retention, and plasma half-life, but no compound has been developed that has minimal adverse effects when given in multiple daily doses. Alternate day therapy (ADT) significantly reduces complications if the physician selects a drug that has a short duration of action in relation to suppression of corticotropin secretion. ADT represents a compromise, wherein the physician uses a treatment schedule that is not as effective as daily therapy in order to minimize undesirable effects.

Glucocorticoids have been used in more than a hundred different diseases. The popularity of these drugs is exemplified by the fact that they were responsible for \$128 million of sales in new prescriptions for American pharmaceutical manufacturers in 1970. This represented 5% of the total sales.<sup>1</sup> One obvious reason for their popularity is their ability to affect many physiological processes and organ systems. This diversity of action has provided a basis for using these drugs to treat many unrelated diseases. Table 1 summarizes, under general categories, most of the indications for using glucocorticoids.

The diversity of action of glucocorticoids can also become a handicap. If a physician chooses to use the hormone for its anti-inflammatory effects

in a patient with arthritis, he can achieve the desired result, but in the process he may swap symptoms of inflammation for symptoms of hyperglycemia, osteoporosis, edema, hypertension and ulcer disease. This is certainly not a good exchange, and other undesirable side effects can develop. Tables 2 and 3 list some of the diseases and laboratory abnormalities that can occur during and related to corticosteroid therapy.

The preceding review has briefly summarized the dilemma in using corticosteroids as therapeutic agents except perhaps as replacement therapy for adrenal insufficiency. Investigators have tried several approaches in attempting to resolve the dilemma. One approach was to alter the chemical structure of cortisone acetate, the first agent available for therapeutic use.<sup>2</sup> Figure 1 shows the structure of cortisone with certain carbon atoms numbered according to convention.

The first modification of cortisone produced hydrocortisone, the naturally occurring glucocorticoid in humans. It differs from cortisone by the replacement of the keto group at carbon 11 with a hydroxyl group. As an antirheumatic agent it is 1.5 times more active than cortisone acetate.<sup>3</sup> Hydrocortisone has a significant mineralocorticoid effect and causes excessive sodium retention and urinary potassium excretion when used in amounts exceeding 50 milligrams daily. In general, it is associated with the same complications that are seen with cortisone. The plasma half-life of hydrocortisone in humans is 114 minutes.<sup>4</sup>

TABLE 1.—GLUCOCORTICOIDS: THERAPEUTIC INDICATIONS.

1. Inflammation
2. Immunosuppression
3. Neoplastic disease
4. Hypercalcemia
5. Hypotension
6. Hypoglycemia
7. Corticotropin suppression
8. Adrenal insufficiency

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Another modification involved the addition of a halogen to the basic hydrocortisone molecule. In 1955, 9-alpha-fluorohydrocortisone was found to have 8-10 times the potency of hydrocortisone in actions such as anti-inflammation, corticotropin suppression, gluconeogenesis, and nitrogen wasting. The increase in the retention of sodium by this compound was even more dramatic and was estimated to be 50 times that of hydrocortisone.<sup>5</sup> It is now used generally in doses of 0.1 to 0.2 milligram daily for its mineralocorticoid effect.

Table 2.—GLUCOCORTICOIDS: COMPLICATIONS.

1. Adrenal cortical atrophy
2. Hypertensive cardiovascular disease
3. Atherosclerosis
4. Thrombophlebitis
5. Vasculitis
6. Esophageal, gastric, duodenal ulcers
7. Pancreatitis
8. Fatty metamorphosis of liver
9. Hyperglycemia
10. Renal lithiasis
11. Osteoporosis
12. Proximal myopathy
13. Nodular panniculitis
14. Psychoses
15. Glaucoma
16. Cataracts
17. Short stature
18. Sexual infantilism
19. Mediastinal lipomatosis

TABLE 3.—GLUCOCORTICOIDS: LABORATORY ABNORMALITIES.

1. ↑ FBS, Abnormal GTT, glycosuria
2. Hypercholesterolemia
3. Hypertriglyceridemia
4. Hypokalemic alkalosis
5. Hypocalcemia, hypercalciuria
6. Urinary nitrogen increase
7. Hyperuricemia
8. Polycythemia
9. Polymorphonuclear leukocytosis
10. Eosinopenia
11. ↓ Serum PBI or Serum T4

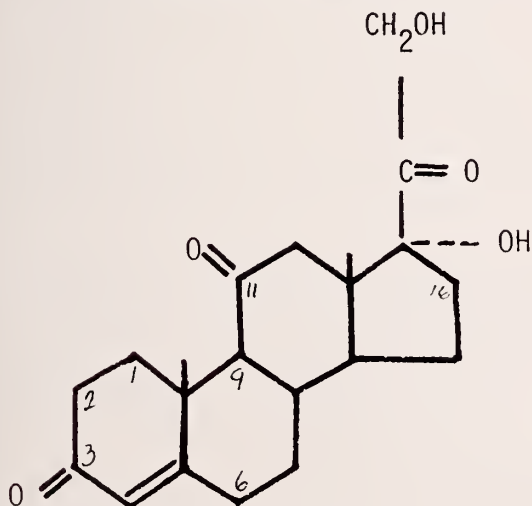


Fig. 1.—Cortisone

In 1955, prednisone and prednisolone were synthesized and differed structurally from cortisone and hydrocortisone by the presence of a double bond between carbon one and two. Prednisolone has a plasma half-life of about 210 minutes in humans,<sup>6</sup> a value roughly two times that of hydrocortisone, but its antirheumatic activity is four times greater.<sup>7</sup> Prednisolone and prednisone have some salt-retaining activity, but rarely cause edema or increases in blood pressure when they are prescribed in the usual pharmacologic amounts. Because of the relative reduction in mineralocorticoid activity, neither of these two steroids can be used as the only drug in replacement therapy in patients with primary adrenal failure. Both drugs are associated with significant adverse effects when used daily in pharmacologic doses. They may cause less hirsutism, striae, and ecchymoses than other glucocorticoids, but seem to have the same risk of weight gain, altered fat deposition and peptic ulcer disease.<sup>8</sup>

Methylprednisolone was also synthesized in 1955. This compound structurally is identical to prednisolone except for the addition of a methyl group at the sixth carbon of the steroid nucleus. Although it is more potent than prednisolone as a glucocorticoid in the rat, it has only equal anti-rheumatic activity in humans.<sup>9</sup> Its plasma half-life is 188 minutes.<sup>10</sup> It has become a very popular drug and is frequently used in organ transplantation protocols<sup>11</sup> as well as in treating certain types of shock.<sup>12</sup> It is rarely associated with edema and does not cause sodium retention when used in the usual therapeutic doses.

The addition to prednisolone of a fluorine at carbon nine and a hydroxyl group at carbon 16 resulted in triamcinolone. This drug has considerable more glucocorticoid and anti-inflammatory potency in rats than prednisone,<sup>13</sup> but in humans it is about equal to prednisolone in the relief of symptoms of rheumatoid arthritis<sup>14</sup> and is twice as potent in treating asthma. It has very little mineralocorticoid activity. Triamcinolone has some unusual side effects including headaches, somnolence, anorexia, nausea, abdominal pain, and weight loss. It has been noted to occasionally cause weakness, fatigue, and muscle atrophy with more marked nitrogen wasting than other steroids. It is frequently used to treat dermatologic disorders.

Dexamethasone represents another structural modification of prednisolone. It has a fluorine atom at carbon nine and a methyl group at car-

bon 16. In rats, it has 190 times the anti-inflammatory effect of hydrocortisone, but in humans it demonstrates only 25 times the potency of the latter when treating the pain of rheumatoid arthritis.<sup>15</sup> It is a much more potent glucocorticoid than prednisolone, yet it has about the same plasma half-life of 170-210 minutes.<sup>15</sup> Although it has minimal mineralocorticoid activity, edema has been shown to be a rare complication.<sup>8</sup> Some investigators have suggested that it is less likely to aggravate a glucose intolerance than other glucocorticoids if given in equivalent anti-inflammatory doses.<sup>16</sup> This drug is primarily used for diagnostic purposes (corticotropin suppression) and in treating cerebral edema.

The efforts to alter the structure of cortisone have only produced compound differences in the degree of sodium retention, plasma half-life, and glucocorticoid potency. No compound has been produced that has minimal adverse side effects when used in pharmacologic doses, particularly when administered as multiple doses daily.

#### Limiting Adverse Side Effects

The biggest advance in limiting the adverse side effects of glucocorticoids has not come from structural modifications, but from variations in dose schedule. Originally, treatment with these hormones consisted of multiple doses daily aimed at maintaining a constant drug level in plasma at all times. However, it became rapidly apparent that such round-the-clock treatment could produce serious metabolic abnormalities, even though the total amount of hormone did not greatly exceed the normal endogenous secretion. One treatment schedule that retained an anti-inflammatory effect and minimized undesirable effects was the administration of the total dose on alternate days. Harter, working with Dr. George Thorn in Boston, helped develop this concept of alternate day therapy [ADT]. His initial study group involved patients with severe chronic asthma who had been on long term steroid therapy.<sup>17</sup> He gave them twice the total daily dose as a single dose every other day. In many of these patients symptomatic relief could be sustained on this schedule and several benefits were noted: (1) some recovery of adrenal function which made discontinuation of steroids easier, when therapeutically possible, and (2) some reduction in undesirable effects on bone and connective tissue.

Subsequent studies have demonstrated more

conclusively the benefits of alternate day therapy.<sup>18</sup> Cushingoid features only rarely develop with ADT and children treated in this manner have had little of the usual steroid suppression of linear growth.<sup>19</sup>

The efficacy of ADT relies on the observation that many of the effects of glucocorticoids persist long after measurable plasma levels of the particular drug have returned to normal. In addition, it has been shown that some of the effects of steroids continue longer than others. The anti-inflammatory effect seems to persist for 36 to 48 hours following administration of the drug, but the duration of the effect is somewhat dependent on the basic disease under treatment, the drug used, and the total dosage given. The hyperglycemic effect of glucocorticoids in humans is usually less than 24 hours in duration when the total dose is given in the morning. Walton et al<sup>20</sup> have shown that the duration is somewhat dependent on the total dosage administered. A 15 mg dose of methylprednisolone produces an effect for 10 to 12 hours, and a 90 mg dose causes changes for 18 to 22 hours. Studies also clearly indicate that the inhibition of corticotropin secretion does not persist for 24 hours after giving the total dosage of a "short acting" drug in the morning. However, it is not clear that the effects on nitrogen and calcium balance are shorter than the duration of the anti-inflammatory effect.

Other factors that influence the degree of success of ADT in reducing the morbidity of glucocorticoid treatment are the choice of the drug and the route of administration. Only glucocorticoids that are short-acting should be used. A short-acting compound is one that suppresses corticotropin secretion for less than 24 hours. This does not correlate with plasma half-life, which has been reported to be approximately 200 minutes for both short-acting prednisolone and long-acting dexamethasone. Table 4 shows a categorization of some commonly used glucocorticoids based on their duration of suppression of corticotropin after a single dose of the drug given in the morning.<sup>21</sup>

Table 4.—GLUCOCORTICOIDS DURATION OF ACTION: SUPPRESSION OF CORTICOTROPIN SECRETION

Short-Acting	Hydrocortisone
	Cortisone
	Prednisone
	Prednisolone
	Methylprednisolone
Intermediate-Acting	Triamcinolone
Long-Acting	Dexamethasone



Some parenteral preparations of glucocorticoids such as triamcinolone diacetate and cortisone acetate suspensions should never be used in ADT protocols because of the prolonged pharmacologic actions that result from their use.

While ADT has significantly reduced the morbidity associated with glucocorticoid therapy, this type of dosage schedule does not retain the maximal anti-inflammatory effect achieved when equivalent total doses of the hormone are given as multiple doses daily. Most of the time ADT should be considered a form of maintenance therapy. For most diseases the initial therapy should consist of multiple doses daily; for example, 10 to 25 mg of prednisone every six hours. Complete symptomatic relief can usually be obtained in three to ten days, and this duration of therapy rarely results in prolonged suppression of corticotropin secretion and subsequent adrenal atrophy. Once the inflammatory manifestations are under control, the patient can be changed to ADT. The transition can usually be accomplished by giving the total daily dosage as a single dose at 7 to 9 a.m. for five days, then doubling the total dosage, and giving this amount between 7 to 9 a.m. every other day. The total dosage should be reduced at intervals in order to determine the smallest amount that will keep the patient functional and reasonably free of symptoms.

Physicians are frequently faced with the problem of converting patients who have been on prolonged daily therapy to ADT. ADT requires a relatively intact hypothalamic-pituitary-adrenal axis, and changing from daily therapy must be gradual. If the patient is on multiple doses each day, he should initially be changed to an equivalent dosage given at one time in the morning. Once the patient is on a single dose daily, then

one of two protocols, depending of the disease under treatment, can be followed in changing to ADT:

- (a) If the disease may flare when the treatment program is altered, then the "off" day dosage must be lowered slowly, allowing several days at each level. The amount of hormone removed from the "off" day should be added to the "on" day.
- (b) If the disease is not likely to flare, but the patient has significant suppression of the hypothalamic-pituitary-adrenal axis and adrenal atrophy, then the patient is placed on double the usual total daily dosage of hormone on alternate days, and on the "off" day is given the equivalent of 5 mg of prednisone.

One final point should be reemphasized. Patients on ADT receive the maximal anti-inflammatory effect on the day they receive the medication. Some symptoms may be present on the "off" day. This is particularly true for such conditions as bronchial asthma and rheumatoid arthritis. These "off" day symptoms are the most common reason for disillusionment with ADT, but are rarely so pronounced as to incapacitate the patient. Aspirin can frequently be used in patients with rheumatoid arthritis to control these symptoms. It is important to educate the patients about the possibility of having some symptoms on the "off" day and acknowledge that ADT is a compromise that results in some symptomatic relief and minimizes complications.

References are available from the authors upon request.

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## Main Culprit in the Malpractice Mess

The cost of defending and paying malpractice claims against British doctors is up 250% in six years, says the British Medical Defence Union. Yet the causes cited in the U.S. don't apply. Contingent legal fees are banned, no juries of laymen hear malpractice cases, and standardized medical fees are unlikely to trigger suits. The Defence Union blames the rise on inflation.

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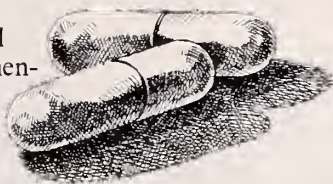




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**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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# Florida's Physician Needs in the Fall of 1973 Measured by the FMA Physician Placement Service

EUGENE L. NIXON

Florida is oversupplied in many specialties and undersupplied most acutely in family practice and emergency medicine. This is the general conclusion which may be drawn from a recent tabulation of current statistics from the Florida Medical Association's Physician Placement Service.

On September 15, 1973, there were 290 physicians registered with the FMA Placement Service as actively seeking practice locations. At the same time, there were 186 opportunities listed throughout the state.

Of the physicians registered, internists were the largest group (49), followed by general surgeons (41), family practitioners (29), and ophthalmologists (21). The doctors seeking Florida practices were located in 30 states and territories and in four foreign countries. More of the registrants were located in New York (50) than in any other state, followed by Florida (46), New Jersey (24), Pennsylvania (21), Ohio (16), Illinois (14), California (11), North Carolina (11), Texas (10) and Alabama (8). The remaining physicians were scattered through 24 other states and nations. Of all physicians registered, 60 per cent were foreign born and educated.

The medical opportunities or vacancies were spread over the state from Pensacola to Key West. Not surprisingly, they did appear to be concentrated in areas of high population (see Figure 1).

The medical specialty which appeared to be most oversupplied in Florida is radiology. There were 13 radiologists registered for each opening in that specialty. Calculated in the same manner with the number of registrants for each opening shown in parentheses, the other specialties appearing definitely oversupplied were pathology (10),

anesthesiology (7), general surgery (7), orthopedic surgery (6), urology (6), psychiatry (5), dermatology (4), and ophthalmology (3). Internal medicine would appear to be oversupplied, with 49 internists registered and only 26 openings shown, but this puzzling fact may be misleading. The relatively large number of family practice opportunities listed (64) could well absorb many internists.

TABLE 1

Specialty	Physicians	Opportunities
Allergy	3	3
Anesthesiology	13	2
Cardiology	9	5
Colon/Rectal Surgery	1	0
Dermatology	8	2
Emergency Medicine	1	14
Family Practice	29	64
Gastroenterology	4	1
General Surgery	41	6
Internal Medicine	49	26
Institutional/ Governmental	—	8
Neurology	3	1
Neurosurgery	2	0
Obstetrics/Gynecology	17	11
Ophthalmology	21	8
Orthopedic Surgery	12	2
Otolaryngology	7	10
Pathology	10	1
Pediatrics	13	16
Pediatric Surgery	1	0
Plastic Surgery	2	1
Psychiatry	9	2
Public Health	1	0
Radiology	13	1
Thoracic Surgery	4	0
Urology	12	2
Unspecified	5	—
TOTALS	290	186

Mr. Nixon is Director, Scientific and Medical Services Department, Florida Medical Association.



The most acute need continues to be in family or general practice, with only 29 physicians registered in that category for the 64 openings. These openings were in urban, middle-sized and rural communities. There also is a continuing and growing need for full-time emergency physicians throughout the state. This emerging new specialty, of course, draws currently from a number of specialties in medicine and surgery. A complete tabulation of physicians and opportunities registered is contained in Table 1.

In analyzing these data, it must be kept in mind that these physicians and opportunities are

only those actively registered with the FMA Physician Placement Service as of a specific date. The number of such listings varies seasonally and even day to day. It probably could be viewed as a barometer of Florida's physician needs.

Physicians with knowledge of medical opportunities are urged to contact the FMA Physician Placement Service, P.O. Box 2411, Jacksonville 32203, telephone (904) 356-1571.

► Mr. Nixon, Florida Medical Association, P. O. Box 2411, Jacksonville 32203.

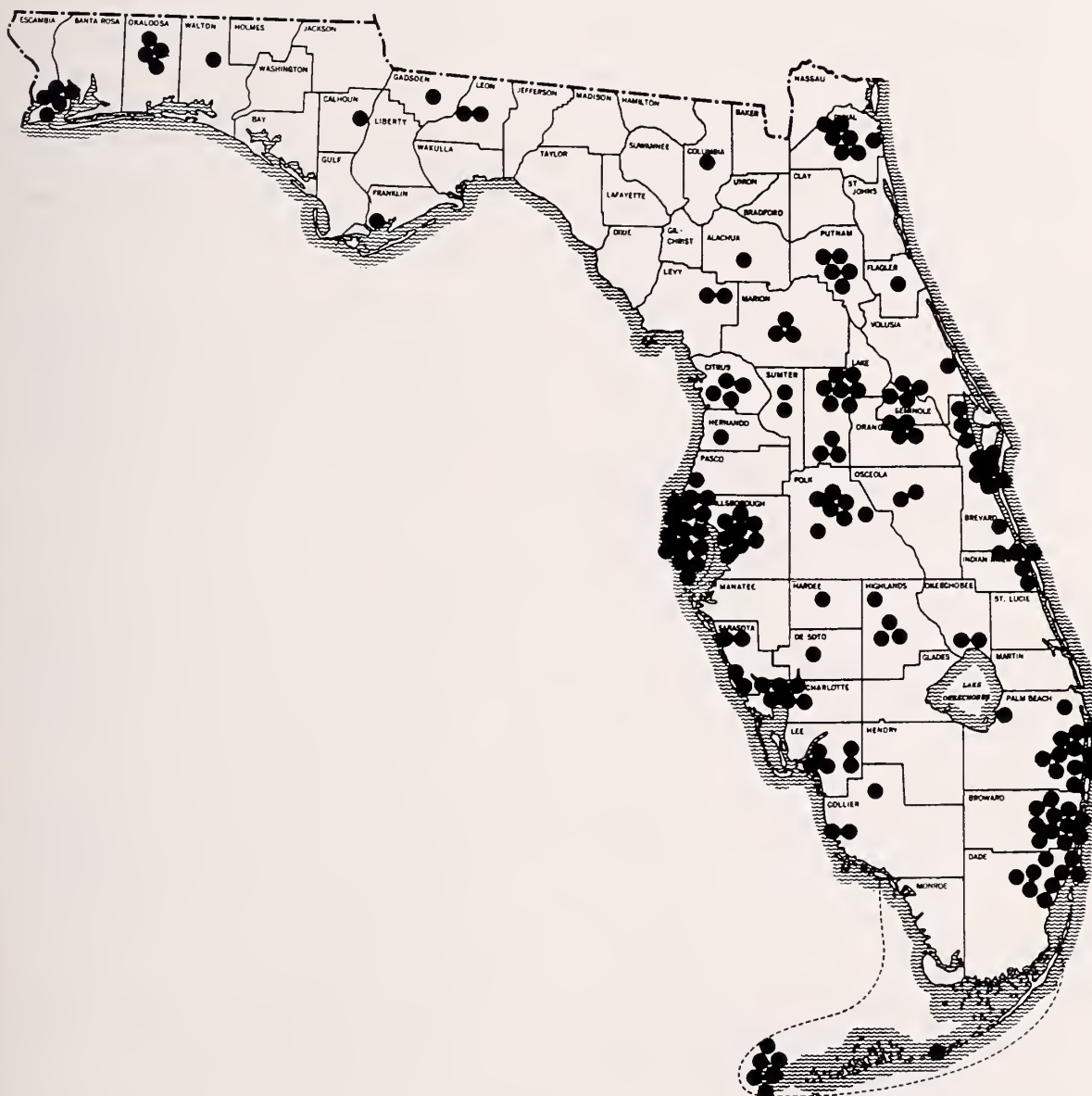


Figure 1.—Medical Opportunities in Florida Registered With FMA Physician Service as of September 15, 1973.

# MEETINGS

Approved by FMA  
Committee on Continuing Education

## DECEMBER

- 1 Pediatric Pre-Football Game Seminars, J. Hillis Miller Health Center, Gainesville. For information: George A. Richard, M.D., Shands Teaching Hospital, Gainesville 32601.
- 7- 8 High Risk Pregnancy and Gynecologic Oncology, South Building Auditorium, Cedars of Lebanon Health Care Center, Miami. For information: Director of Education, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125.
- 10-11 Infant Nutrition for the Practicing Physician, University of the South Florida College of Medicine, Tampa. For information: Lewis A. Barness, M.D., University of South Florida College of Medicine, Tampa.

## JANUARY

- 2- 5 Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Eden Roc Hotel, Miami Beach. For information: Div. of Continuing Education, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.
- 6-10 Neuro-Ophthalmology Symposium, Sonesta Beach Hotel, Miami Beach. For information: Joel S. Glaser, M.D., 1638 N.W. 10th Ave., Miami 33136.
- 8-11 Special Procedures in Diagnostic Radiology, Playboy Plaza Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.
- 9-11 International Symposium on "Recent Advances in Clinical Electrophysiology: His Bundle Electrocardiography," Mount Sinai Medical Center of Greater Miami, Miami

## JANUARY (continued)

- Beach. For information: Frances Richardson, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.
- 9-12 Postgraduate Seminar in Pediatric Neurology, Eden Roc Hotel, Miami Beach. For information: Robert Cullen, M.D., University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.
- 14-19 Courses in Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.
- 31-Feb. 3 Nineteenth Central Florida Medical Meeting presented by Orange County Medical Society and Seminars and Symposia, Contemporary Plaza Hotel, Disney World. For information: Seminars & Symposia, Inc., Box 1537, Richmond, Va. 23212.

## FEBRUARY

- 4- 9 Courses of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.
- 4- 9 Florida Midwinter Seminar in Ophthalmology and Otolaryngology, Americana Hotel, Miami Beach. For information: Nadia S. Giddens, 7545 South Waterway Drive, Miami 33155.
- 22-24 Pediatric Dermatology Seminar, Fontainebleau Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

Next FMA Annual Meetings: May 8-12, 1974, Hollywood





## Editorials

### More, Better and Less Costly Medical Care?

At the 1972 Clinical Convention of the AMA a resolution was introduced calling for a moratorium on further "Certificate of Need" legislation. Little support for this action was voiced and the House of Delegates adopted a substitute resolution, directing the Council on Medical Service to collect and study all available data on such laws. Obtaining information on all proposed legislation along with copies of enacted laws, the council has submitted a report describing comprehensive health care planning as a mandate for controlling health care costs, enacted in 23 states and proposed in many others. The acts are patterned, generally, after those regulating public utilities, such as telephone companies, common carriers and electric and gas companies, yet, to date, there has been no judicial findings that the health care industry should be so regulated. While the middle-aged health industry has never been regulated like the so-called "public utilities," under free enterprise there is no competition so prices are contained or people can have a free choice in selecting their hospital. For since it would be considered unethical for hospitals to advertise, patients can't really make an informed decision. Expressing an intent to promote comprehensive health planning, so as to assist in providing the highest quality health care at the lowest possible cost and avoiding unnecessary duplication of facilities, the need philosophy hopes to provide orderly methods for resolving questions concerning the necessity for changes in facilities where health care is provided. The law has been contested in three states and in North Carolina declared unconstitutional and repealed. There the Supreme Court decreed it unconstitutional on the basis that it tends to produce a monopoly. For if the need in a community were for only one hospital, that hospital could virtually charge whatever it wanted. Advocated as one method for

controlling health care costs, the laws, where enacted, have not followed a common pattern since only hospitals are covered in some states, but in Florida, California and New York hospitals, nursing homes and other types of facilities are specifically mentioned.

The mixed reaction to the Certificate of Need legislation is that it can be a two-edged sword. Intended to cut costs, avoid duplication, and increase accessibility by excluding nonconforming institutions from reimbursement for capital expenditures through federally funded programs, it can stifle competition, be extremely time consuming, expensive and may not appropriately address the problem of duplication.

Special interests must be prevented from taking control and prudent judgment by all members of Comprehensive Health Planning Councils should be undertaken. Rather, should not competition be encouraged by creating new types of incentives for the providers who should be responsible more to the public than to political expediency. Both sides generally agree that regulation appears needed to avoid unnecessary expenditure but objecting to the concept of government intervention in community and private enterprises, there has been lack of agreement that the law has been successful in controlling waste or forming a viable decision that doesn't take forever. Aiming to establish the optimal mixture of health facilities and services in a community, the law by opponents is a restrainer on private property.

Actually, the Certificate of Need refers to a process through which some governmental agency reviews a health care provider's proposal to initiate, expand or change facilities and services, and determines whether the applicant should be granted or denied permission to carry out the proposed project, using the needs of a community for the

proposed health care program as a measuring stick. The first state to pass such law was New York in 1964; however, the Hill-Burton Act in 1946 authorized grants for region-wide planning of hospital facilities, and an enactment of the Community Health Services Act of 1961 supported planning on an area-wide basis. In 1966, the Comprehensive Health Planning Act focused national attention and effort on the establishment of voluntary health planning bodies. While the ownership and control of many acute care facilities lies in charitable, community or private hands, the need for public regulation of these resources may be exacted by the sharply rising rate of increase in costs for services with payment more and more coming from public tax revenues.

A finite amount of resources is available from society to invest in the health field so that as the percentage of the gross national product devoted to health care increases, the amount of resources available for other basic social needs is correspondingly reduced. The physician, in an intimate relationship with his patient, has as a first responsibility that of providing to him optimal care. When faced with decisions about hospitalizing patients vs. providing ambulatory care, pressing for shorter length of stay, or recommending less costly services, the physician quite properly is influenced in his decision by concerns about the individual patient. The planning council, however, must use the total resources available for health care to allocate them in a manner that will produce the best quality care possible for the greatest number of people. While most health facilities are nonprofit institutions using donated capital, their

decision-making process concerning capital expenditures often lacks adequate scrutiny or control in an unregulated market place.

A number of critical problems must be debated if Certificate of Need laws achieve their goals. These include: Criteria for determining needs that are not established in clear and objective terms. Planning bodies, especially at the local level, are often poorly informed and make improper decisions. The Certificate of Need does not encourage closing unneeded or overlapping facilities and services. Leverage to force a merging of existing inadequate services is not provided. Quality issues, and the problems of manpower resources such as a disproportionate production of physicians in certain specialties, or the geographic placement of physicians have not been evaluated.

State and area-wide planning boards must have the benefit of thoughtful participation from all segments of society so that decisions can be carefully made at the lowest possible levels. While there is some provision for physician input into the decision-making process regarding Certificate of Need, this subject should be looked at more closely. Physicians must actively participate in these review and regulatory bodies, and critically assay all decisions, for prudent judgment should be the hallmark of all such legislation.

C.M.C.

### References

1. Report C of the Council on Medical Service, Certificate of Need Laws, Actions of the House of Delegates, AMA Annual Convention, 1973.
2. Dorsey, Joseph L.: Certificate of Need Laws, Arch. Surg. 106:765-769 (June) 1973.
3. Is 'Certificate of Need' Needed? Medical World News, August 24, 1973.

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*Two University of Connecticut psychologists have just completed a survey designed to determine how the public views different occupations—in terms of "honesty." In all, the survey listed twenty occupations for the public to choose from, listing the most honest at the top and the most dishonest at the bottom.*

*Here's the ranking, beginning with the most honest and ending with the most dishonest: 1. physicians 2. clergymen 3. dentists 4. judges 5. psychologists 6. college professors 7. psychiatrists 8. high school teachers 9. lawyers 10. law enforcement officers 11. TV news reporters 12. plumbers 13. business executives 14. U. S. Army Generals 15. TV repairmen 16. newspaper columnists 17. auto repairmen 18. labor union officials 19. politicians 20. used car salesmen.*

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Reprinted from the Georgia Intelligencer, July 1973.



## The Doctor and Politics

Recently, while enjoying a respite between legislative duties, health problems and the fate of my romantic endeavors, I received a call from my doctor (without benefit of going through the nurse or *friendly* answering service). The excitement in his voice was evident from the first word, but so was the chagrin. He had just had an opportunity to get hold of a copy of the recently passed HR-1 Social Security Act. It contained the Bennett Amendment (authored by Senator Robert Bennett of Utah).

For those less fortunate than my doctor, let me say if the Bennett Amendment is enforced with the same ineptness as the other portions of Medicare it will tighten the noose of socialized medicine around the doctor striving to avoid it. Essentially what it does is set up review committees whose duty will be to compare the treatment, both length of stay and medically, being received by the Medicare patient against the care being received by the private paying or non-Medicare patient with the same diagnosis.

How do you suppose a committee, which I might add does *not* have to be composed of all doctors, arrive at their conclusions without looking at the private patient's record? Well, someone forgot to say and to date it hasn't been broached.

Even more stringent utilization review requirements have been established going so far as to require the doctor to predict when the patient may recover (if at all).

It is an insidious amendment when fully read and understood if the implications present in the text reach full maturity. It flies into the face of the 5th Amendment of the U. S. Constitution according to some of my more learned jurist friends.

One final note on the Amendment, an HEW official told me that you fellows are lucky, you should have seen the one introduced by Senator Ted Kennedy. Lucky for you it didn't pass.

How does medicine get itself into such condition? First, it was Medicare pure and simple, then along came the HMO concept and now the PSRO.

Well, the doctors of this nation are so busy keeping 300 million people healthy that little time

can be found to keep up with what is going on within the office much less in state legislatures and in Washington.

Organized medicine, like most organizations, pay lots of money to skilled professionals to protect their interests; from experience, I can tell you they can offer only so much protection.

Local level medical societies are going to have to begin an educational program far superior to those in existence to educate each doctor on the finer points of protecting himself from the over-promising political types found in Washington if they are to survive.

There are many things a doctor can do right within his office. Each month when statements are mailed, a mimeographed letter could be enclosed, advising the patient that the local Congressman or Senator has voted not in the interest of medicine, and a brief explanation of why he feels this way. It may take 30 minutes of your day off to prepare, but if things keep going the way they are you will have to get a leave slip from HEW to get the day off anyway.

One good example is that explaining the rise in the cost of living is as much responsible for rising costs of medicine as anything else. The cost of nurses, specialists, technicians in the lab, equipment, all are higher, so it necessarily follows that fees need to be adjusted to meet the increase. Why let the politician blame doctors when the problem is not limited to the medical profession? Doctors need to write personal letters to their elected officials and let them know that they will be watching with keen interest their position on medicine. There are two things a politician understands—votes and money. Without either he is like a fish out of water.

If you have an opportunity to read the Bennett Amendment, disregard that phrase "nothing in this act is intended to interfere with the private practice of medicine," since they already have done so by passing the bill. Congress continues to be the one place where abortion is practiced daily without benefit of a consultation. Senator Bennett offered his amendment as his legacy which may be a poison for which there is no antidote.

PAUL SULLIVAN

Mr. Sullivan is on leave of absence from his position as Administrative Assistant to the Senate, State of Florida.

► 400 - 34th Street, North, St. Petersburg 33713.

## Against Air Bags

Air Bags are great for two groups:

1. Properly positioned anesthetized baboons in the right front seat of an automobile crashing headon at 30 MPH or less—if the air bag works.
2. Manufacturers of air bags, who stand to realize a three billion dollar bonanza—based on the estimated cost of \$100-\$400/car for ten million new automobiles per year.

27% to 32% of deaths and injuries occur in headon collisions. Non headon collisions are unaffected by air bags, which are not touted as safety measures for side crashes, rear crashes or rollovers. That leaves 68% to 73% of the people now being killed still unprotected if they depend on air bags.

The air bag salesmen say one should wear a lap belt for these emergencies. Actually, if one wears a lap belt no air bag is needed. The lap belt alone is protective in almost 85% of all crashes. The additional crosschest shoulder strap adds another 15% safety factor. The Volvo report of some 28,000 crashes for all occupants wearing lap and crosschest revealed, “. . . . full protection against fatal injury up to accident speeds of 60 MPH.”<sup>1</sup>

The diagonal chest strap should never be used without the lap belt as this has led to decapitation and death from neck and spinal cord injuries.

Even better than the standard cross-chest belt is the inertia-locking reel, which offers protective support for the head and neck in rearend collisions and additionally distributes the load to both shoulders in headon crashes, side impacts and rollovers.

In the 400-500 deaths I have seen while treating several thousand crash victims, there was not one fatality to a seat belt wearer. In 15-20 of injured occupants wearing seat belts, all logical evidence said they should have been badly injured or dead, yet the seat belts had saved them. Some had crashes at speeds up to 85 MPH yet suffered no injuries or had relatively minor ones.

Many people say they wear their seat belts “. . . only on long trips.” Any use of seat belts is good, of course, but statistics show that only 25% of injuries or deaths from accidents occur

“ . . . on long trips,” which is usually defined as being more than 25 miles from home and at speeds over 50 MPH. The other 75% happen *within* 25 miles of home at speeds *under* 50 MPH—exactly where the use of seat belts and shoulder harnesses would be most effective.

The commonly expressed fear of being “trapped” by the seat belt in a car involving fire or a plunge into water is authoritatively refuted by the Florida State trooper statement that 85% of the people dredged out of the canals which crisscross this area have made no apparent effort to get out of their submerged cars. They wore no seat belts, and therefore were rendered unconscious on impact with the water, by smashing against the dashboard, windshield or headliner of the car. Apparently they drowned before regaining enough consciousness to struggle out. The “second crash” of the unrestrained body against the inside of the car cannot occur if the occupants are buckled in.

The same safety factor exists in the car that catches fire after a crash. The seat belt restrained occupants remain alert and uninjured. It takes only one second to disengage the seat belt and run away from the burning car. The unrestrained are unconscious or too injured to escape.

Only *mandatory* seat belt legislation will force their use and thereby markedly reduce this terrible tragedy of injury and slaughter on the highways. 90% of the people are law abiding and would therefore obey a law to use their seat belts. The 10% who aren't would quickly reveal themselves by their smashed state. Insurance benefits could be reduced or cancelled and law suits could be interdicted on the basis of contributory negligence for those who flaunt the law and don't have their seat belts and shoulder harnesses fastened when they crash.

Seat belts and inertia-locking shoulder straps are not the entire answer to auto safety.

The above comments in no way downgrade the necessity for better roads, sturdier cars, driver education courses, reduced speeds, control of the drinking driver, etc.

*But*—the seat belt and shoulder straps are proven effective. They are safe. They are cheap. They are reliable. And they are here and now.

T. NORLEY, M.D.

► 528 Northwood Road, West Palm Beach 33407.

1.—Volvo Study-Sweden



## Education: Heightened Appreciation of the World

In the heat of the moment when the class of 1973 honored me as their recipient of the Hippocratic Award, I volunteered to give a talk to the class banquet that night. In their wisdom, perhaps garnered from hearing me talk in an impromptu fashion on philosophy before, they recognized that it would take me more than a few hours to pull together my thoughts and provided me with this forum.

The opportunity to give a sanctioned open-ended talk is welcome. Some of you know that I do not follow course content at all times, which I gather can be hazardous to a professor's job occasionally, but maybe it made the reading of electrocardiograms a little more interesting than the computer.

I would like to think with you a moment regarding medical education, knowing that you realize that when an inhouse graduation speaker speaks that what he is really saying is, "I want one more whack at you."

Perhaps it will be worthwhile to consider first the meaning of education itself. My view of the role of education is that it is to assist an individual to incorporate as many as possible of the multitudinous events, objects, and ideas of our universe onto the framework of his own being. In other words, education should widen one's perspectives and deepen one's perceptions. For some this may mean the exploration of new areas, research if you like, and creation of new concepts. For all it should mean a heightened appreciation of the world which we all share. Hopefully, the tedium of what might otherwise be routine tasks can be lightened by the appreciation of sometimes subtle nuances. It is implicit in this concept that the mere retention of material which is narrowly oriented toward a specific need or goal is not to acquire an education although it may lead to a good living. The honey bee can also deliver the bread by translating a returning worker's hop, skip and jump in a particular orientation to the sun and by following the directions to the nearest clover patch. I would be less than candid if I did not question if the trend to make education

"relevant" may not make it too mission-oriented with insufficient underpinnings in the basic science areas. If so, I trust that you will make the necessary efforts to correct this as you continue your education.

As an aside, I will express my belief that one of the current bits of dogma which has led to a narrowing of education and may produce idiot savants who can recite endless facts and manipulate complex technical equipment without true comprehension is the misconception that "new knowledge is growing at a logarithmic rate." Much of the "new knowledge" is a filling in of the details surrounding a truly new fact which appeared decades ago. In the area of cardiology, for example, many of the fundamentals of muscle contraction were deduced from 20 years to over half a century ago by Otto Frank, Starling, Hill, Huxley, and others. Surely, though, the number of papers on myocardial contractility has grown logarithmically in the past couple of decades. Clearly much has been learned in this period, but has the ratio of new information to paper bulk been 1:1? This is neither an attack on research or education at large but is an expression of the view that unquestioning worship of the tenet that the growth in information has been so rapid that it is impossible to comprehend even the main concepts in fields other than those in which one is directly involved creates a psychological block against attempting a broader comprehension; it may also serve as a shield to cover up the narrowness of some so-called disciplines.

Do not interpret the preceding as an alignment with those who attack education, as is often fashionable now. Indeed, I will point out a none too subtle way in which education is often downgraded. One hears comments about the educated person who does not have much common sense, or that a person with a degree in one discipline cannot think any better in another area than any other man on the street. I must admit that when Linus Pauling advocates vitamin C for the common cold, I have second thoughts myself even if a lot of it does come from Florida orange juice. However, by my definition of education the basic thought processes of the educated chemist, social scientist, or mathematician are the same and can be applied to other areas even if the specific tools

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Dr. Taylor is Professor of Medicine at the University of Florida College of Medicine, Gainesville, and recipient of the Fifth Annual Hippocratic Award for Teaching Excellence. This address was presented before members of the College's June graduating class.

of his or her day to day chores are different. Linus Pauling is far more able to think clearly on a problem related to international society than is Li'l Abner. I hasten to add that I am not advocating some form of intellectual elitism or even suggesting that universities have a monopoly on education. But I would defend the proposition that the universities of our world have the prime responsibility in this area, at least for setting the tone.

One of the major benefits to be derived from the wider horizons which I believe education should convey is a flexibility in responding to the world around one. Flexibility does not mean some kind of spinelessness or inability to make a decision. Those of you who have thought with me about the physical and emotional problems of our mutual patients know that I detest reading at the end of a long examination an impression which says rule out, better yet R.O. peptic ulcer, R.O. PPGI (these are initials for a fancy term meaning nervous stomach), and three or four more rule out's. My comment has often been that those who do not make decisions soon lose the capacity to do so; accordingly, sum up the available evidence and decide what you think the patient has. Decisions can be changed but if no intellectual moment of truth is reached, one never knows, even in retrospect, if they interpreted the data correctly. The emotional elation of solving a difficult problem can never be savored because no solution but rather a group of amorphous maybe's was proposed.

The flexibility to which I am alluding can be very demanding because it comes from a perception of the many factors which may have acted in concert to produce an event which in turn will interact with many others to cause other reverberations. It incorporates a realization that a commonly held view may be false and that one must consider all possibilities including the ideas which others hold and still not get lost in a morass of indecisiveness.

As young physicians you are going to have to be flexible in many areas where ironclad tradition has provided a security cocoon for generations of physicians before you. Your relationship with the allied health professionals—nurses, inhalation therapists, radiation biologists, nutritionists, among others—will have to be one of shared responsibilities and respect rather than that of captain and soldier. And, like the Women's Lib Movement, when we all get used to it, we'll be

happier. You will have to be flexible in your responses to the inevitable and, I feel, desirable changes in our nonsystem—as it has been described, tongue in cheek—of health care delivery and finance. Patients, too, deserve new empathies and a better partnership in the understanding and planning of their health needs.

I hope that your years in our midst have aided in your educational maturity so that you can face the challenge for medicine, as well as society at large, with an ability to examine the problems openly, objectively, and then decisively in order to make creative decisions.

Finally, I must indicate my view of the most important role of education which is particularly fitting when one considers that Hippocrates, whose venerable oath you will shortly embrace, symbolizes a blending of science with humanism and high ethical standards. Without intending to usurp any territory from my colleagues in religion, I believe that education, however achieved, should serve to mold, to develop, and to protect the integrity of individuals, a process which in concert establishes the moral foundation of society at large. The deeper awareness of the needs of those around us which education should produce carries with it a responsibility to behave in a more perceptive fashion, rather as outlined in the Parable of the Talents in the Bible. We must be aware of the influence of our actions on our fellowman and that a dog eat dog philosophy of survival may have been the *modus operandi* of physical evolution but that social evolution requires other laws. Physical evolution required millions of years to substitute a single more effective amino acid in a hemoglobin chain, a period of time which would prohibit any of us enjoying the fruits of any social evolution which were that time consuming. We must at least sense the fundamental incongruity of our saying we own a tree which was on the earth 300 years before we were, and were it not for us might be here another 200 years. We must be able to recognize a false tenet, even though it be cloaked in seemingly convincing garments. We must have the courage to expose falsehood and to support the principle of basic integrity.

Perhaps even more importantly, we must recognize the fallacy of the proposition that the end justifies the means and must be aware of our application of it—a difficult task in view of man's great tendency toward self-deception. I believe our country is now experiencing deep spiritual tur-



moil which stemmed largely from a lack of appreciation of that simple premise. When I was in high school the dogma was that matter and energy were the two distinctive and inconvertible constituents of our world. Now quantum physics has revealed that matter and energy are different expressions of one whole. Likewise, the end and the means become one in practice; an ignoble method demeans any objective just as an unethical

objective cannot be cleansed by the most polished technique.

It has been my privilege to be associated with you the past few years. I will cherish your Hippocratic Award and watch your future careers with affection and pride.

W. JAPE TAYLOR, M.D.

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## Cholera After 62 Years

The recent problem with cholera in Italy has attracted considerable attention in the news media and prompted a virtual flood of telephone calls through public health switchboards in the United States. Local outbreaks of cholera have been reported by Italian health authorities in the vicinities of Naples and Bari. It would appear from news reports that the situation is under control at the present.

The causative organism in Italy has been reported as an El Tor biotype, serotype Ogawa. The El Tor biotype has been responsible for the pandemic spread of cholera beginning in Indonesia in 1961 involving the Middle East by 1966 and extending to Europe and Africa during the early 1970's. This biotype is interesting in that many more asymptomatic cases result from infection with this agent than occur with the classical biotype. Some studies have shown that for each diagnosed and reported case there may be as many as 25 to 100 persons with mild or asymptomatic infection; therefore, with modern jet travel it is easy to see how this disease could be transported across international borders by persons with asymptomatic cholera.

In spite of the fact that more than half of the world's inhabitants live in cholera infected areas, the risk to Americans traveling abroad remains low especially if the usual prescribed precautions are followed.

Field trials in endemically infected areas have shown that currently available cholera vaccines reduce the incidence of clinical illness by about 50% but are effective for only three to six months. Furthermore, they do not prevent transmission of disease. Cholera vaccination is not required for travelers returning to the United States from an endemic or epidemic area. Since other governments may require evidence of vaccination of persons coming from infected areas, vaccination is recommended for people traveling to Italy and other countries with cholera.

The first nonlaboratory acquired case of cholera occurring in the United States since 1911 was reported September 1, 1973. The infection presented in a 51-year-old male Texas resident with no history of travel or contact with persons recently coming from foreign countries. It was caused by the El Tor biotype, serotype Inaba, therefore, is unrelated to the Italian problem previously described.

Investigation into the possible source for this case involves the location, historic review and medical examination of approximately 200 persons who spent at least one night in a Texas motel which appears to have been the immediate focus of the infection. These efforts are in progress.

WYNN H. HEMMERT, M.D.

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# Rondomycin® (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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## ORGANIZATION

# Our Greatest Allies The Voluntary Health Agencies

ROBERT E. WINDOM, M.D.

Only in recent years have physicians begun to see the value that medicine derives from the function of many voluntary health agencies. Most physicians have felt that only lay people participated in these organizations with only a few physicians serving as advisors or special consultants. They believed that fund raising was virtually the only activity and that people got involved simply because they had a special interest in a particular disease.

Today things are different and it behooves us to look into the status of this aspect of medicine which is moving further ahead each year in the total program of health services.

Although there are virtually hundreds of organizations that solicit funds for one health cause or another, there are very few that carry on a balanced program which is very necessary in order to be recognized officially as a voluntary health agency. Besides that, the Florida Medical Association has established a list of criteria that an organization must meet if it desires to seek official recognition by the FMA.

At this time, there are fourteen such recognized voluntary health agencies serving in the State of Florida. These agencies are: (1) American Cancer Society, Florida Division, Inc.; (2) Arthritis Foundation, Florida Chapter; (3) Easter Seal Society for Crippled Children and Adults of Florida, Inc.; (4) Florida Association for Retarded Children; (5) Florida Epilepsy Foundation; (6) Florida Heart Association; (7) Florida Society For The Prevention of Blindness, Inc.; (8) Florida Lung Association (formerly the Tuberculosis

and Respiratory Disease Association); (9) Mental Health Association of Florida, Inc.; (10) Florida Kidney Foundation, Inc.; (11) Leukemia Society of America, Florida Division; (12) National Foundation—March of Dimes; (13) National Multiple Sclerosis Society, State of Florida; and (14) United Cerebral Palsy of Florida.

These agencies and a few others have joined together to form a composite group known as The Florida Voluntary Health Association (FVHA). This body consists of one volunteer and the executive director of each one of the member agencies. They function to help coordinate activities, share ideas and work together to improve means by which each agency can better serve its members and supporters.

For the first time this year, the FVHA has formulated a reference directory which can be of valuable assistance to each physician in the State of Florida. A brief report about each agency is provided, indicating what its main functions are and how the money is spent to operate the organization. Equally important is a listing of officers of each agency throughout the state which provides an opportunity for any physician to contact the appropriate source when needed. These directories have been sent to each County Medical Society office and each Society Secretary. Any physician may request one if he desires for his own personal use.

After being recognized by the FMA, an agency is given a certificate which it can display appropriately in its headquarters and its respective branch offices throughout the state. Each year the organization must re-apply for subsequent annual recognition and in so doing, show evidence of

Dr. Windom is Chairman of the Council on Voluntary Health Agencies of the Florida Medical Association.



maintaining its quality of performance in order to continue to meet the standards of the FMA. Any other voluntary health agency that wishes such recognition may request information from the FMA office in Jacksonville, to determine if it qualifies. Action is taken by the FMA Council on Voluntary Health Agencies each year on new applicants.

Many physicians may look at this and say, "So what? How could this affect me?" But once he gets involved in any one of these organizations he will have an entirely new outlook on this matter. In Florida alone the 14 agencies recognized by the FMA raise more than \$10 million per year. This is big business by anybody's standard. The expenditure and distribution of this huge sum of money requires the wisdom of dedicated individuals.

Granted that many knowledgeable lay people devote many hours to this task, the expertise in medical judgment by physicians is essential to see that this form of the health dollar stretches to the maximum in improving the health of our citizens. Research activities are vital to help find cures for the many diseases included in the spectrum of these agencies. This is more apparent in the past year since governmental support of research has declined in certain areas. Also the red tape involved in obtaining government money far surpasses the relative ease of receiving a grant from a voluntary health agency when a qualified researcher is in need of support. Only through the cooperative effort of responsible physicians serving these agencies can this function be properly performed.

Professional education programs provided by these agencies offer the practicing physicians valuable postgraduate education that often cannot be obtained by other means. Community service and lay education programs offer the public a valued return for their investment in these voluntary health causes. By enlightening the non-professional in this manner, he is made more aware of what benefits result from his contribution. Some agencies also provide funds for service to patients who otherwise could not afford medical assistance necessary to correct or improve a particular health need.

To say that the voluntary health agencies serve as medicine's greatest ally is redundant after one realizes all of the functions rendered by these organizations. The job ahead is to get more and more physicians to take an active role in one or

more of these agencies so that much greater benefits will accrue to all concerned in the future. Besides this, physician's service in this manner portrays to the lay public that the doctor is truly devoted to this broader scope of health problems and wants to share his time and talent toward making these programs more successful. A passive consequence from his participation is the intangible benefit that results from the public becoming more knowledgeable about the problems facing medicine today as expressed by a physician who sits side by side with another volunteer working for a common cause. This is just another effective method to help bridge the gap of understanding between medicine and the public.

An example of what is forthcoming as a result of the cooperation of many voluntary health agencies is a series of five special medical documentaries that will be presented over 237 interconnected Public Broadcasting Service stations across the nation beginning November 19, and continuing through next March. The 90-minute programs, titled "The Killers", are designed to inform the public about methods of prevention early detection, and treatment of the five medical conditions that took 1.5 million lives and accounted for 75.7% of the deaths in United States last year.

The first program, "Heart Disease: The Twentieth Century Epidemic" is scheduled November 19; "Inborn Genetic Defects", December 17; "Pulmonary Disease", January 14; "Trauma", February 11; and "Cancer", March 11. This series is made possible by a grant from Bristol-Myers & Co. with assistance in production by an advisory board of 23 representatives from the health and medical professions. Local PBS stations will use these shows as springboards for community action to plan programs that will tie into this national series. Many are developing follow-up activities, such as, lectures, workshops and demonstrations. Therefore, one can readily see the magnitude of the effort by voluntary health agencies to play a dynamic role in the improvement of health for all mankind.

► Dr. Windom, 1750 S. Osprey Avenue, Sarasota 33579.

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Petty feelings always get  
lost in a big person.

# A Status Report to the FMA Membership on PSRO

October 1972—PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS appeared as a federal law which on January 1, 1974 establishes voluntary M.D., D.O. organizations to review all institutional care paid for by Medicare, Medicaid and Maternal and Child Health programs as to medical necessity, quality and the appropriateness of the facility.

May 1973—The FMA House of Delegates adopted the following policy. . . . authorized the establishment at the earliest possible date of the Florida Professional Standards Review Organization, Inc. . . . The primary purpose of this corporation is to serve as the prime contractor for the State of Florida. . . . and for not less than 12 local PSRO's which shall provide local review and professional services.

June 1973—The Florida Professional Standards Review Organization, Inc. was incorporated under the laws of Florida on June 21, 1973. Each county medical society in Florida was offered the opportunity to participate in its formation and designation of local areas. The organizational meeting was held and Burns A. Dobbins, M.D. of Fort Lauderdale was elected president. The Florida Professional Standards Review Organization, Inc. filed application with the Secretary of Health, Education and Welfare and HEW Region IV to be recognized for the entire state. Each member of Florida's Congressional Delegation was asked to contact Secretary Weinberger of the Department of HEW, on behalf of the FPSRO, Inc. Secretary Weinberger advised that state medical associations would be consulted but avoided the question of recognition of Florida as one area. Confusion in Washington has continued to delay policy determination in this area.

September 1973—Each member of the Florida Congressional Delegation was contacted again on September 24 to request the Secretary of HEW to recognize FPSRO, Inc. and Florida as one area. The FMA will continue to pursue the statewide approach and try to prevent fragmentation of the profession in Florida.

The President and the Executive Committee concurred in their disenchantment with this ill conceived, illogical federal legislation which will usurp and infringe upon the private practice of medicine in this nation. The FMA Board of Governors agreed to support legislation introduced in the Congress to repeal the PSRO Law. If you wish to contact your Congressman the Bill is H.R. 9375.

FMA Legal Counsel has been requested to determine the feasibility of an injunction against HEW if they refuse to designate Florida as one PSRO area.

If additional information is desired regarding FMA activity or policy, please advise the FMA Executive Office.

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## Gaining Wisdom

A man is acquiring wisdom if, sooner or later, he discovers that life is a mixture of good days and bad, victory and defeat, give and take. If he learns that it doesn't pay to be a too-sensitive soul; that he should let some things go past him. If he learns that he who loses his temper usually loses out, that all men have burnt toast for breakfast sometimes, and he shouldn't take a fellow's grouch too seriously.

If he learns that carrying a chip on his shoulder is the easiest way to get into trouble, that the quickest way to become unpopular is to carry tales of gossip about others. If he learns that buck-passing always turns out to be a boomerang, that it doesn't matter so much who gets the credit so long as the job gets done.

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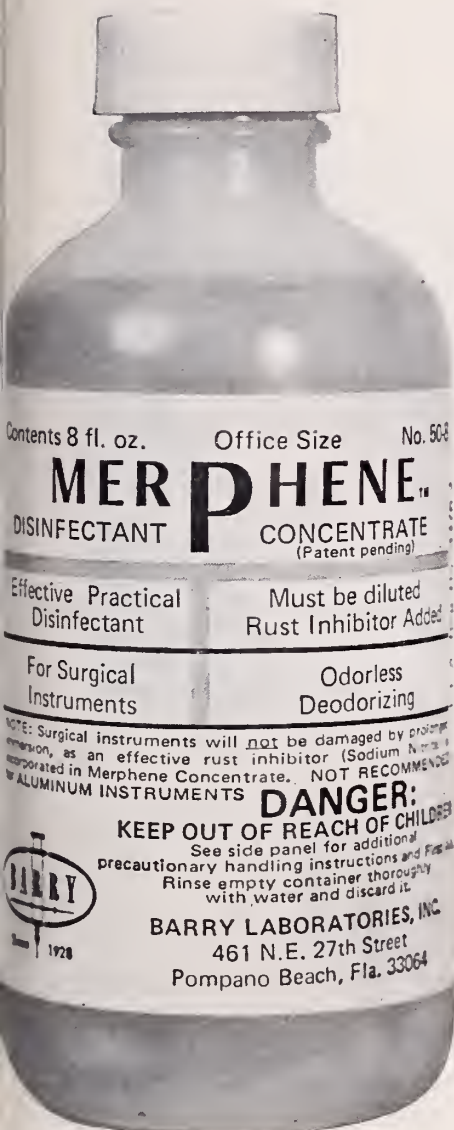
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## **Medical News**

### **Mailman Center Gets Director**

Robert S. Stempfel Jr., M.D., has assumed duties as Director of the Mailman Center for Child Development at the University of Miami School of Medicine.

Dr. Stempfel, who comes to Miami from the University of California School of Medicine at Davis, also assumed titles as Professor and Vice Chairman of the Department of Pediatrics. He received his M.D. degree in 1952 at Vanderbilt.

### **Optometry Stamp Protested**

The American Association of Ophthalmology is protesting the American Optometric Association's petition for a commemorative postage stamp.

In a letter to Postmaster General E. T. Klassen, AAO Secretary Lawrence A. Winograd, M.D., expressed his organization's opposition to the statement "Optometry—Your First Line of Defense Against Blindness," which the optometric group wants printed on the stamp.

"This statement is not in accord with fact and will mislead the public," Dr. Winograd wrote.

"We do not here discuss the merits of a commemorative stamp for optometry," he further added. "We protest the issuance of a stamp which would identify optometry as a 'defense against blindness,' or in any other way by statement or depiction identify optometry with the diagnosis or treatment of disease or injury."

### **IMA Lists Openings**

Physicians wishing to go into industrial medicine either full-time or part-time are invited to write for the Employment Referral Service Bulletin, published monthly by the Industrial Medical Association. Opportunities throughout the country are listed.

A free copy may be obtained by writing to the Industrial Medical Association, Employment Referral Service, 150 North Wacker Drive, Chicago, Ill. 60606.

### **Second Dental Class at Florida**

The University of Florida College of Dentistry has enrolled its second class of 24 students.

The new class was selected from an original pool of 617 applicants and includes two women. All but two of the first-year dental students are Florida residents.

### **New Official at Miami U.**

Gerry B. Mendelson, Ed.D., has been appointed to the newly-created post of Assistant Dean for Curriculum at the University of Miami School of Medicine.

Dean Emanuel M. Papper, M.D., said Dr. Mendelson's duties includes evaluation of current medical teaching programs and implementation of new methods designed to facilitate the learning process.

The new Assistant Dean earned B.S. and M.A. degrees at New York University and received his Doctor of Education degree at Indiana University. He went to Miami from Michigan State University, where he was Director of the Biomedical Communications Center and Associate Professor in the College of Human Medicine.



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## The Medical Profession's Relationship To Blue Shield

GEORGE R. DUNLOP, M.D.

Although there are some 60 HMO's in the country covering about 8 million people and Foundations in at least 40 states most of us are solo practitioners or practicing in small groups on a fee-for-service basis.

Our track record is good. All surveys show that the public likes us as individuals if not in organized groups. Through continuing education most of us are giving our patients good medical care. Since 1950 infant mortality has dropped from 29% to 18%. In the same period the life expectancy of the population has risen from 68 years to 71 years. We have built more medical schools and trained more doctors. So much new information has been generated that our fund of knowledge can become obsolete in a very few years. We have accepted more self-imposed controls than any other profession in the nation. We set up Blue Shield Plans all over the country initially to finance only low income groups and now to cover new and growing health needs of the nation. And finally as a profession we are well paid.

In spite of this record we find ourselves under constant attack by the media, government, labor and the public generally. Public polls show that as a group we are felt to be indifferent

to the public need. Malpractice suits are increasing in number. As bills are drawn up and legislation passed we see more and more of our prerogatives being taken away from us. We are inundated by red tape and paper work. The time has now arrived when we must have our every professional act reviewed by our peers and under the PSRO legislation the peers will be reviewed by government agencies. We feel pressured and set upon. In desperation a few of our profession have joined unions thereby surrendering more of their freedoms feeling that their only recourse is to fight back through the mechanism of a strike.

### Source and Cause of Pressure

Now let us attempt to identify the source and cause of some of these pressures that have led us into this frustrating situation.

Some may say it is simply because the government wants to take over or that the Blues and the insurance companies have assumed too much responsibility. The list of scapegoats is a long one. I need not remind you that unless it is a dictatorship no government can "take over medicine" without public support. In the long haul it is always the public who calls the tune. Our trouble is that the public is talking to us but some of our profession are either not listening or are a little deaf. Now what are we being told.

Dr. Dunlop is Past Chairman of the Board, Massachusetts Blue Shield and Chairman, Board of Directors, National Association of Blue Shield Plans.

Presented before the Annual Meeting of Blue Shield of Florida, May 10, 1973, at Bal Harbour.



In the first place the public is saying that today medical costs are so high that a major illness would bankrupt 95% of the population and that this fact scares the head of any family household. They are telling us that with taxes, high living costs and inflation they must carefully budget their expenses at the beginning of each year. They need to know what their medical costs will be and as the polls have shown are willing to pay an ever bigger premium for paid-in-full programs. They would like to have that program as comprehensive as possible even if it costs more money.

This is understandable and simple enough but the picture has become far more complicated. To pay for all or part of these premiums a company must take the cash out of the pay envelope and attach the cost of medical care to the product they manufacture. Because of this mechanism the cost of health care of the employee and his family becomes a production cost. The union on the other hand sees mounting health care costs as reducing the residual pot for which they can negotiate. Further, these costs cut down the employee's visible take home pay.

If the worker pays no part of the premium directly he feels no restrictions in using his coverage as freely as he thinks necessary. Government as an employer pays the premiums for the largest single group of employees in the world, numbering some 8 million, and at the same time is responsible for the costs of an increasing number of health programs provided under the law. Because of this relationship of production costs and taxes to medical care the public has become increasingly sensitive to their escalation.

This then identifies the source of some of the powerful pressures that have been brought to bear on our profession. But what about quality control we may ask? These pressure groups previously described assume quality control but are demanding better cost controls. The profession on the other hand assumes cost controls and concerns itself chiefly with quality control. If our voices are to be heard at all, cost controls must be given the highest priority.

Now as government and business look at our system what do they see? They recognize that it is more convenient and remunerative for physicians to care for their patients in a hospital. They see for the most part our services do not have to compete in the open market. They see

that physicians are reluctant to exert controls on their own hospital colleagues. In fact, they suspect that the more services rendered in a hospital setting the better for the doctor. They conclude that the system has poor cost control mechanisms.

The big buyers of medical care are told by their consultants that there are health care delivery systems where the physician shares the risk or underwrites the program. This they say is a financial cost control mechanism. Figures are produced which show that an actual practice utilization of services is down in the HMO environment.

The American people have always preferred incentives to controls and the government has accepted development of HMO's as the strategy for two reasons. First, it offers a financial incentive to physicians to keep costs down and, second, such a system may provide competition in the open market.

Unfortunately there is not time to discuss some of the legitimate questions concerning the future of the HMO's. Harry Schwartz in his book, "The Case for American Medicine," has a good chapter entitled "The HMO Illusion."

Let us simply accept the fact that government in going the demonstration route hopes to make a prepaid comprehensive health care system available on an optional basis in another five years.

In the meantime through the PSRO's data will be made public on how one hospital or area compares with another, summaries of length of stay, information by diagnosis, by sex, age and recipient category and analysis of the number of certifications, requests for extensions, denials of certification, emergency requests, justification for approvals and denials and finally the actual length of hospital stay as compared to the certified stays.

The question naturally arises as to whether the peer review offered by the growing number of Foundations for Medical Care and the PSRO's will furnish the necessary cost controls so that the fee-for-service system can compete in the open market with the HMO's. Can it stand up under the critical scrutiny of the public and ward off the threat of a complete government take over?

### Meeting Public's Need

Earlier in my remarks I identified the source of some of the pressures on medicine today and

implied that they will decrease only as our medical care system can meet the public need. Whereas cost controls have top priority in the public view the quality of the product they are buying is of equal importance. I refer now to paid-in-full programs. Government, business and labor are all demanding this. The bills in the legislative hopper guarantee it. Although no one doubts that the federal government's involvement in financing medical care will continue to increase, there is no doubt that the private sector will go on bearing the burden of much of the financing and most of the administration of delivering health care.

On what will our success depend if the profession is to avoid total bureaucratic control? In the firstplace we must support paid-in-full programs. The public cannot be expected to pay increasingly high premiums with the fear that they are not adequately covered and that they may receive supplementary bills for unpredictable amounts from the profession. Indemnity programs in their view are evidence of the lack of commitment to meeting their needs. If we cannot give them this they will turn to the government who will guarantee it.

Second, we must make the peer review system work. Senator Wallace Bennett has told us that H.E.W. will conduct its own parallel review while the PSRO's are demonstrating their potential capabilities.

Finally, we should consider ways and means of introducing a financial incentive into our conventional fee-for-service system if we are to compete successfully with the HMO's. Our greatest weakness as a profession arises from our fragmented system and our spotty performance as well as our helplessness without experts in the field of marketing, underwriting and electronic data processing so necessary for claims review.

This latter expertise is available to us through Blue Shield and to a lesser degree through the private carrier. Blue Shield was developed and supported by the medical profession and the need

for these corporations is far greater than during the years when they covered a much smaller segment of the population. Rapid changes in our medical economy have made it imperative that some agency equipped with all the modern tools and know-how design and sell the programs, collect the premiums, and distribute them in an equitable manner. We as providers of medical care must work with a system which has all these capacities if we are to function at all. If government were to serve this role the medical profession would have little or no voice in these decisions and policies.

Today there are approximately 1,000 physicians sitting on the Boards of the Blue Shield Plans throughout the country and thousands of others on their supporting committees. What better agency exists to translate our own professional needs and those of the public into effective action? The medical profession needs Blue Shield and Blue Shield could not continue to exist without our support.

Health care costs must increasingly be paid for through insurance premiums. Hopefully they will be administered outside of government and that we physicians will continue to have a strong voice in corporate policies. The only other option open to us is through taxes and the federal bureaucracy. Operating outside any system and turning to the patient for full payment for our services is a shaky option at best.

I personally have committed myself to the private enterprise system where the patient will continue to have a free choice of physician and health care delivery system. I will support the patient's need for a paid-in-full program and cost controls and finally I recognize the right of the physician to have a voice in the selection of his patients and his method of remuneration. I hope you will join me in this commitment.

► Dr. Dunlop, 65 Elm Street, Worcester, Massachusetts 01609.

The confidence we have in ourselves arises in a great measure from that we have in others.

—*Duc de la Rochefoucauld (1613-1680)*



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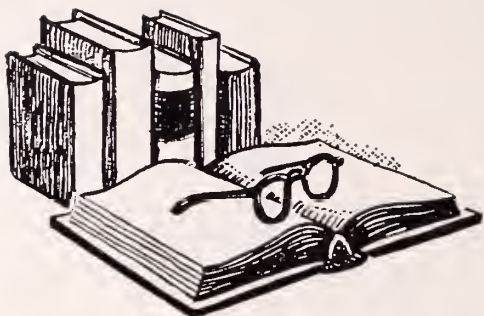
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## Book Reviews

**Lithium in Medicine** edited by Joseph Mendels and Steven K. Secunda. 211 pages. Price \$12.50. New York, Gordon and Breach Science Publishers, Inc., 1973.

Lithium in Medicine represents a comprehensive presentation of the psychopharmacology of one of medicine's oldest psychopharmacological agents (1949). In addition to providing valuable and current information, it vividly depicts both the promise and the complexity of the field of psychopharmacology, a rapidly growing and exciting discipline in medicine. It provides insight into the need for cross communication and translation of animal studies to human studies, of the language of laboratory chemistry to that of clinical medicine, and of the conceptual model to hard data. Indeed, in this text, the common purpose of the clinician and the researcher is reaffirmed.

There are several clinical areas which I found especially refreshing. A rational approach to the treatment of lithium poisoning is presented and discussed. To my knowledge, this represents an original contribution to a previously poorly understood subject. The over evaluation of the plasma lithium level as an index to toxicity is suggested, and a technique for determination of intracellular concentrations is offered. Also, a discussion of the potential benefits and use of lithium in children and adolescents is offered. The author's present evidence that the mechanism of action of lithium and the biochemistry of affective disorders is neither solely a question of biogenic amine metabolism or of electrolyte metabolism, but rather an interrelationship of, at least, the two processes.

I was disappointed by the absence of any discussion of lithium-induced edema. The use of lithium in the geriatric population received minimal attention. This is an area of particular interest to the Florida physician and Van de Velde, has to my mind, pointed to the need for concern.<sup>1</sup> The author's reference to lithium use in pregnancy has recently been updated by Shou.<sup>2</sup> Lithium's contraindication in gastrointestinal disease deserves emphasis.<sup>3</sup> Also, I feel a reference to the drug's potential benefits in thyrotoxicosis, narcotic abuse, convulsive disorders, and aggressive-combative behavior might have been included.

### References

1. Van der Velde, C.D.: Toxicity of Lithium Carbonate in Elderly Patients, *Am. J. Psychiat.* 127:1075-1077, 1971.
2. Shou, M., et al: Lithium and Pregnancy (Parts I, II, III), *British M. J.* 2:135-139, 1973.
3. Ayd, F.J.: *International Drug Therapy Newsletter*, Vol. III, No. 3, March 1973.

WILLIAM THORNTON, M.D.  
NAPLES, FLORIDA

**The Expectant Father, A Practical Guide** by George Schaefer, M.D. 167 pages. Price \$1.95. New York, Harper and Row Publishers, Inc., 1972.

The Expectant Father is a valuable book for prospective mothers as well as fathers and should be required reading for all couples about to become parents. While it is geared toward helping the first-time father know what to expect during pregnancy, labor, and the infant's first weeks, it is a simple, informative course for both parents in some of the more complex aspects of pregnancy and especially in both maternal and fetal health.

The book carefully and specifically instructs the new father in how to make pregnancy a more emotionally satisfying experience for both new parents, without paying attention to the mystique that accompanies it. It attempts to cover everything the prospective father should know, from the financial aspects of pregnancy up to and including where to park the car when he arrives at the hospital emergency room. A valuable glossary is included at the end of the book.

The one fault this reviewer found is that in attempting to clarify some of the newer aspects of obstetrics the author becomes too technical at times. The discussion of amniocentesis and use of ultrasound B-scan becomes a little too complex. The same could be said of the chapter on genetics, which probably should be omitted. Certain terms are used which the author forgets to define (e.g., creatinine, when discussing amniocentesis to determine fetal maturity; spectrographic analysis of amniotic fluid for bilirubin and L/S ratio are not mentioned at all, even though these are newer and more accurate parameters).

More importantly, from the doctor's point of view, it familiarizes the father with medical contingencies which may arise so that he is informed and knowledgeable about what is happening. Dr. Schaefer touches on the first weeks after the baby is born and wisely counsels the father on attitudes toward breast feeding, birth control and family planning, and even how to handle interference from well meaning but domineering grandparents.

Aside from the few minor faults mentioned, The Expectant Father should be required reading for both prospective parents since unlike other related books, it handles competently the physical and emotional aspects in preparing for parenthood. It is highly recommended for anyone involved in the practice of obstetrics.

STEVEN M. WEISSBERG, M.D.  
MIAMI

**The Early Diagnosis of the Acute Abdomen** by Sir Zachary Cope, 14th ed. 210 pages. Price \$6.00 (paperback). New York, Oxford University Press, 1972.

This soft bound classic is still current after 13 previous editions in a span of 50 years. It must be some kind of a record for a book to be edited and revised over this many years by the same author.

Radiographs, drawings and tables are used with the same incisive economy as the text. This book will appeal both to the specialist and generalist. In keeping with the previous format, there is no bibliography, at once an advantage and a disadvantage.

F. NORMAN VICKERS, M.D.  
PENSACOLA



## Books Received

*Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.*

**The Causes, Ecology and Prevention of Traffic Accidents** by H. J. Roberts, M.D. Price \$39.50. 1,016 pages. Springfield, Illinois, Charles C. Thomas Publishers, 1971.

**Anesthesiology Progress Since 1940** by E. M. Papper, S. H. Ngai and Lester C. Mark. 192 pages. Price \$7.95. Coral Gables, Florida, University of Miami Press, 1973.

**Review of Physiological Chemistry**, 14th ed. by Harold A. Harper, Ph.D. 545 pages. Illustrated. Price \$8.50. Los Altos, Calif., Lange Medical Publications, 1973.

**Synoptic Functional Neuroanatomy** by Wendell J. S. Krieg, Ph.D. 74 pages. Illustrated. Price \$6.00 (cloth), \$5.00 (paper). Evanston, Ill., Brain Books, 1973.

**Seeing and the Eye** by G. Hugh Begbie. 227 pages. Illustrated. Price \$2.95. New York, Anchor Press/Doubleday, 1973.

**Dr. Thompson's New Way For YOU to Cure Your Aching Back** by Jess Stearn. 203 pages. Illustrated. Price \$7.95. New York, Doubleday & Company, Inc., 1973.

**Physician's Handbook** (17th ed.) by Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, M.D., Edward G. Biglieri, M.D. and Robert L. Roe, M.D. 728 pages. Illustrated. Price \$6.50. Los Altos, California, Lange Medical Publications, 1973.

**Cancer Diagnosis in Children** by L. D. Samuels, M.D. 131 pages. Illustrated. Price \$26.00. Cleveland, Ohio, CRC Press, 1972.

**The Diabetic Foot**, edited by Marvin E. Levin, M.D. and Lawrence W. O'Neal, M.D. 262 pages. 249 illustrations. Price \$25.50. St. Louis, The C. V. Mosby Company, 1973.

## Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

**Author Responsibility.** The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

**Synopsis-Abstract.** All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

**References.** The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

**Illustrations.** Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."



## "My Favorite Things"

The tune for this month is 'My Favorite Things'. They include the Auxiliary Fund-raisers.

The American Medical Association Education and Research Foundation (AMA-ERF) has been the only fund raising project of the National Auxiliary since 1962 when it was organized. The purpose of the AMA-ERF program is to help eliminate the financial barrier to medicine for all who are qualified and accepted by an approved training institution. This purpose is two-fold—(1) to provide unrestricted grants to medical schools, and (2) to enable medical students, interns and residents to obtain low interest loans not otherwise available. Our national goal this year is to raise \$1 million for AMA-ERF. Florida Auxiliary contributed the sum of \$44,638.52 last year while the National Auxiliary contribution totaled more than \$965,000 to AMA-ERF. We raise these funds in a variety of ways. The biggest money maker is the Auxiliary County 'Sharing Card' at Christmastime. The sales pitch is that we do not need to send cards to each other, the 'Sharing Card' wishes all a Happy Christmas and your contribution goes to your favorite medical school or the loan fund as you so designate. Your donation of an amount suggested by your Auxiliary is tax deductible. The local Auxiliary committee signs, addresses, stamps and mails all cards and one card with all names of the local medical society comes to each member during the holiday. At least a 50% profit is made on this project depending on the expense of the type card, postage and number who subscribe to the it. Other money makers are: special and costume watches, jewelry, stationery, note paper, recycled 'rapping' paper, glamorous scarves, tablecloths, napkins and placemats are just a few of our favorite things we sell to raise funds for AMA-ERF.

The Florida Medical Foundation is a nonprofit organization having for its purpose "to promote better medical care in Florida." The objectives

include the purpose, sponsorship of graduate and postgraduate medical education, aid to persons of Florida pursuing an education in medicine who need financial assistance, aid to deserving indigent or destitute Florida physicians who by reason of illness or mental or physical incapacity need charitable assistance and it promotes and sponsors medical research exclusively for public purposes and benefits. Since 1969, the Auxiliary has been sponsoring medical seminar tours to different parts of the world and shipments of seafood and citrus fruits out of the G & S Packing House, Weirsdale, Florida with benefits going to your Florida Medical Foundation. This year, in addition to these projects, the Auxiliary is editing a cookbook 'What's Cookin', Doc?' which will be available to the County Auxiliaries at the Fall Board Meeting and Conference the last of October. All monies, after expenses, will go to FMF. Many of you have given us your favorite recipe and you will want to have one for your very own, plus some to give away as gifts.

On an international scale, for many years the Auxiliary has sponsored an IHA (International Health Activities) Bazaar at our State Fall Board Meeting and Conference where each County Auxiliary brings unique items for sale and all proceeds go (1) to our adopted Indian Child under SKIP (Scholarships for Kids of International Physicians) where \$360 provides a complete year's board, room and education for a child of a physician in India who is willing to practice in medically deprived areas of his country as long as his child is satisfactorily educated—this program was designed just for this project—and (2) other projects where our financial assistance is needed such as Project Hope and this is chosen by vote of the Auxiliary Board. Last year, the bazaar raised \$1,192.50 and after our Indian Child was taken care of, the balance was sent to Direct Relief for the people of Nicaragua.



At Convention time each year, the Auxiliary sponsors an Art Show with benefits going to the Museum of Florida's Medical History in St. Augustine. We presented the Museum to the FMA, the St. Johns Medical Society and to all those persons visiting the ancient city via sightseeing tours on July 26 of this year. Each year we give you rules and regulations that all entries must follow in the Art Show such as: (1) an entry fee of \$10, (2) only one artist's name should be listed with each registration, (3) pictures must be framed and wired for hanging, (4) *must* be original work, (5) Doctors, their wives and children are eligible to enter and so forth. This page will not come out in the FMA Journal until the first of the year, but you must start your entries now—paint, sculpt, sew, snap pictures and create your own thing for this year's Centennial Convention next May 1974. Let's make this the biggest show, yet.

The remaining fund-raising project is usually done on the local scene and that is for our scholarships. Tasting dinners, fashion shows, card parties, book reviews or some other event raises many thousands of dollars which are either loaned or given to worthy students going into a health related vocation.

These are just a few of 'My Favorite Things' and I hope that your wife helps to write the score in your County Auxiliary's melody this year.

Your singing conductor,  
Mrs. W. H. (Mary Ann) Mathews,  
President, WA/FMA



## Letters

Dear Editor:

I thought it would be of interest to relate my personal experience with acupuncture and moxibustion. In 1970, I developed a facial neuralgia which localized to the left upper central incisor; root canal therapy and an apiectomy did not solve the problem. I then tried Dilantin and Tegretol with no relief. In 1971, x-rays of my sinuses revealed "a minimal degree of mucous membrane thickening of all the paranasal sinuses, more extensive involvement of the right maxillary antrum." I obtained some relief with Valium and the use of topical steroids to the nose. In February, 1973, I consulted a neurologist and a diagnosis was made of "Dysethetic nasal sensory syndrome in association with chronic rhinitis and sinusitis likely secondary to causalgic disturbance of the submucous distal branches of the maxillary division of the trigeminal nerve." I was advised to continue with the topical steroids and Valium.

In March, 1973, I received a brochure from the University of Florida College of Medicine announcing a pain seminar at which one of the participants, Philip M. Toyama, M.D., was going to conduct an acupuncture clinic. I wrote Dr. Toyama and went to Galax, Virginia for treatment. I received both acupuncture and moxibustion. Dr. Toyama instructed Mrs. Alper in giving the moxibustion treatment. The pain disappeared completely after several weeks of treatment. The moxibustion was discontinued about one month ago and there has been no recurrence of pain.

LOUIS ALPER, M.D.  
MIAMI

### "What's Cooking, Doc?"

Available November 1, 1973

Your Auxiliary offers you this book of exciting and tantalizing recipes which will not only tickle your taste buds but will also introduce you to many of the gourmet chefs among our Florida physicians and their families. Copies will be available through your local Auxiliary.

\$5.00 (plus 75¢ for mailing)

All proceeds will be utilized for appropriate purposes by your Florida Medical Foundation.

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A private hospital for diagnosis and treatment of psychiatric and  
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## Classified Ads

### physicians wanted

#### Family Practitioners

**WANTED**—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

**FAMILY PRACTITIONER** to join 15 man multispecialty group in Central Florida. Excellent fringe benefits together with pleasant working facilities in an area famous for excellent recreational opportunities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

**FAMILY PRACTITIONER** to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

**CENTRAL FLORIDA AREA:** Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

**FAMILY PRACTITIONERS WANTED:** One of the fastest growing communities in the U.S., Seminole, Florida, urgently needs family practitioners. Only minutes from Tampa, St. Petersburg, Clearwater and beach areas. Newly opened 100-bed acute general hospital. Offices provided on hospital property with rent free provisions. Will assist in referrals of patients. Write or phone Carlton K. Flores, Administrator, Lake Seminole Hospital, 9675 Seminole Boulevard, Seminole, Florida, 33542. Phone (813) 393-4646.

**DIPLOMATE ABFP DESIRES IMMEDIATELY:** FP or GP to associate in active suburban practice Palm Beaches. Florida license required. Attractive salary, P. A. benefits and partnership opportunity. Contact J. Randolph, M.D. Phone (305) 965-8222.

#### Specialists

**INTERNIST, UROLOGIST, GP's:** Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

**INTERNIST**, board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

**PATHOLOGIST, AP-CP**, Florida license. Only candidates with outstanding qualifications and references need apply. Excellent group opportunity, lovely medium size Florida east coast community. Write C-607, P.O. Box 2411, Jacksonville, Florida 32203.

**PHYSICIANS WANTED:** General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 East 25th Street, Hialeah, Florida 33013. Phone (305) 696-0842.

**UROLOGIST WANTED:** Association leading to partnership in expanding Florida community, equally distant from both coasts. Florida license and board certification required. Write C-614, P. O. Box 2411, Jacksonville, Florida 32203.

#### Miscellaneous

**DUNEDIN**, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

**PHYSICIANS NEEDED:** Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

**INTERNIST, FAMILY PRACTITIONERS:** Central Florida area, Orange County. Area combines best of rural living with easy access to metropolitan area 11 miles away. Privileges available in expanding hospital. Contact Robert Barber, Administrator, West Orange Memorial Hospital, 555 North Dillard Street, Winter Garden, Florida 32787. Phone (305) 656-1244.

**PHYSICIANS WANTED:** St. Augustine (Flagler Hospital) desires the following Florida licensed physicians to meet the growing community needs: General Practitioner and Otolaryngologist. Free space in new professional building. Financial assistance available. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone (904) 824-8411.

**WINEMAKING**—A quiet retreat from the hectic cares and responsibilities of the day. Send for free informative catalog. Arbolyn Wines, 829 Knox Abbott, Cayce, S. C. 29033.

**DEVELOPING MULTISPECIALTY GROUP** oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Urologist, Internist, Cardiologist, Pediatrician, General Surgeon, Orthopaedist, and OB-GYN. Contact: H. D. Williams, M.D., President, Marlowe, Williams, Abbey & Sells, MDs, PA. Richey Medical Center, P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

**EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY:** to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of \$40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital.

**EMERGENCY ROOM PHYSICIAN** needed in 180-bed hospital located in Southwest Florida. Fast growing community, rotation with another physician. Contact Sister Mary Augustine, Administrator, St. Joseph Hospital, Port Charlotte, Florida 33952.

**WANTED:** ER physician in lovely coastal city in southwest Florida. Excellent facilities, pleasant staff relations, advanced program, quite adequate remuneration, top quality position in established program. Please send curriculum vitae and inquiries to C-613, P. O. Box 2411, Jacksonville, Florida 32203.

**EMERGENCY ROOM PRACTICE**—Full time emergency room practice in 67-bed county hospital with 900-1,000 visits per month. New 120-bed replacement hospital under construction for summer 1975 occupancy. Independent practice with hospital guarantee, 40 hour week, excellent circumstances and financial potential. Located in growing city of 14,000 population on beautiful St. Johns River in heart of northeast Florida lake, river, and wooded recreation area. Only 28 miles east of beaches, too. Contact J. Larry Sims, Administrator, Putnam Memorial Hospital for details, 501 South Palm Avenue, Palatka, Florida 32077. Phone (904) 328-1451.

## situations wanted

**UROLOGIST:** Completing University training July '74. Age 30, married, board eligible, Florida license. National boards, desires association leading to partnership or group practice anywhere in Florida. Fred P. Sherman, M.D., 20 Lakeview Avenue, Apt. C, Leonia, N.J. 07605. Phone (201) 461-2538.

**Ph.D. CLINICAL CHEMIST,** 6 years clinical laboratory director, Florida clinical lab director's license; Medicare approved; desires position in hospital/clinic/lab/doctor's office. Part time or full time. Write C-615, P.O. Box 2411, Jacksonville, Florida 32203.

**CLINIC MANAGER/BUSINESS MANAGER** desires change, multi-specialty or medium sized group. Experienced in all phases of accounting, billing, insurance, personnel recruitment, physician recruitment, purchasing, patient flow and ancillary departments. Six years hospital and clinic background. Salary range \$20,000. Write C-590, P.O. Box, 2411, Jacksonville, Florida 32203.

**ALLERGIST:** Chest physician, age 43, certified allergy. Academic position university-affiliated hospital; head, chest and allergy sections. Experienced chest disease, pulmonary function lab., tuberculosis, RICU, etc. desires association with established practice, group or consider progressive hospital lab. Inquires: John McCloskey, M.D., 2380 Packard Ave., Huntington Valley, Pa. 19006.

**GENERALIST:** Mature, 30 years+, experience general medicine, industrial medicine, surgery. Wishes to relocate in Northeast Florida area. No OB-Surgery. Limited hours preferred, associate or share practice. Write C-611, P. O. Box 2411, Jacksonville, Florida 32203.



GENERAL SURGEON; University background, Henry Ford Hospital trained, board eligible, available July 1974. Now deciding future practice site. Florida license; will consider association, partnership or full time institutional position. Write N. Khouzam, M.D. 21555 Audrey Street, Dearborn, Michigan 48124.

OTOLARYNGOLOGIST, EXTENSIVE EXPERIENCE IN PLASTIC AND COSMETIC SURGERY seeks association with established specialist or group, or will purchase practice in Miami area. Speak fluent Spanish and French, hold both North and South American medical degrees. Available part or full time. Not seeking semi-retirement. Write C-616, P.O. Box 2411, Jacksonville, Florida 32203.

OB-GYN: A 37 year-old Junior Fellow, married with two children completing residency June 1974. No military obligation, seeks association in Florida, has Florida license. Contact Thomas H. Robinson, M.D., Department of Ob-Gyn, University Hospital, Pensacola, Florida 32501.

UROLOGIST, Board qualified, age 31, military completed June 74. Desires association with established urologist leading to partnership. Write: Stuart Wanuck, M.D., 28 Riverside Ave., Red Bank, N. J. 07701 or call (201) 747-1818.

CARDIOVASCULAR, THORACIC AND GENERAL SURGEON. Age 34, Mayo Clinic trained (general) and university trained (cardio-thoracic). Board certified general, eligible thoracic. Prefer general, thoracic and vascular practice and seek association, group or clinic type practice. Available June 1974. Contact Terrance Havig, M.D., 1425 Pine Meadow Rd., Lexington, Kentucky 40504.

## practice available

OFFICE AND/OR PRACTICE FOR SALE: GP retiring. Modern 2,700 sq. ft. office. Sized for 1-3 physicians as is, enough land to expand for group. Near hospital. Beautiful resort community on East coast of Florida. Contact John P. Gifford, M.D., 2120 - 15th Ct., Vero Beach, Florida 32960.

FOR SALE OR FOR RENT: 1,200 sq. ft. medical office. Equipped and furnished. Corner lot—good parking space. \$225 monthly or \$22,500 minimum down payment. Widow willing to carry first mortgage on balance. Contact Mrs. Willis F. Evans, 66 Star Lake, Pensacola, Florida 32507. Phone 456-2612.

DERMATOLOGY — ALLERGY PRACTICE AVAILABLE IMMEDIATELY. University town with medical school. Suitable for either specialty. No money down. Terms arranged. Must leave practice because of ill health. Contact Irving Weintraub, M.D., P. O. Box 1229 (1330 N.W. 13th St.), Gainesville, Florida 32602. Phone (904) 372-3695.

## real estate

PRIVATE SUITES FOR IMMEDIATE OCCUPANCY: New 18,000 sq. ft. building with excellent parking. South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

ORLANDO—MEDICAL SUITE in modern building, prime location, near hospitals and schools, loads of parking, doctors needed in this area. Phone: (305) 293-6020.

PRESTIGE OFFICE AVAILABLE for immediate occupancy. 1,040 square feet located directly opposite major hospital, ideal for specialty practice. Contact Dr. Leo Conn, 921 N. 35th Avenue, Hollywood, Florida 33021. Phone (305) 966-2268.

VENICE: NEW ULTRAMODERN THREE STORY DOCTORS GARDENS BUILDING now under construction directly opposite the Venice hospital. Occupancy January 1974. Design your office requirements while under construction. Contact: Dr. Sheldon Wald, 2700 S. Tamiami Trail, Sarasota, Florida 33579. Phone (813) 955-4323.

FOR RENT: Facing Memorial Hospital, Hollywood, Florida. From 1,000 to 4,000 square feet. Contact Yale Citrin, M.D., 3435 Johnson Street, Hollywood, Florida 33021. Phone (305) 989-7441.

## equipment for sale

FOR SALE: Mobile x-ray unit, 50 MA. Write Mrs. Paul Hutchins, 1708 West Road, Jacksonville, Florida 32216.

FOR SALE: Concord Sport Fisherman, 33 ft., 1970, twin engines, generator, A C, two radios, equipped for fishing. 20 knots cruising, excellent condition. Foster Bullard, M.D., 328 Fifth Avenue, S., Naples, Florida 33940. Phone (813) 649-8196.

**Classified advertising rates are \$5 for the first 25 words or less and 20 cents for each additional word. Deadline is first of month preceding month of publication.**

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# Seasons Greetings



# JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.



VOL. 60, NO. 12

DECEMBER 1973



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

# Valium® (diazepam)

To help you manage excessive psychic tension

# JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

DECEMBER, 1973 • VOLUME 60 • NUMBER 12



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DECEMBER COVER — The cover was designed by Wanda L. Bain, Director, Administrative Services of the FMA and expresses the sentiments of the entire editorial staff.



## President's Page



### November 16, 1973, Cape Canaveral

At 9:01 a.m. on November 16, 1973, the last scheduled manned space flight left Cape Kennedy. This mission concludes a decade of American supremacy in manned space travel.

We in medicine can learn a valuable lesson from the space program—not only from its miraculous achievements, but also from the reasons for its demise.

The Apollo program was designed with the initial objective of achieving a manned lunar landing and safe return to earth in the 1960's—a goal thought by many to be impossible. In July, 1969, the first astronaut took that “one small step for a man, one giant leap for mankind.” We all can recall the pride that we felt upon achieving the impossible. The space program has, of course, produced much more than lunar landings. There are many other contributions all designed to enhance man's way of life and add to his knowledge of his planet and the universe.

Even the best informed persons are still momentarily stymied when confronted with the fact that the Space Program costs about 25 billion dollars. But when one realizes the mere monitoring devices, a space technology product, now used in CCU's enable one nurse to do the work of many as she essentially “specials” several patients, some knowledgeable physicians have indicated this new system alone increases by 10 to 30% the coronary patient survival rate. Converting these figures to people means 1-3 out of 10 coronary victims are living today who would have otherwise met their complete demise had it not been for the space program; therefore, I contend that the “spin-offs” alone would justify the total expenditure dollar for dollar of the space program compared to any previously attempted medical research program.

Millions of words have been written on this subject, yet, the average American doesn't read the scientific papers or Congressional Record and has not received the message. Many of our legislators, therefore, are more interested in funding welfare programs than space programs. Why do I relate this story? Because medicine's story is similar. We are so busy practicing our art we have failed to tell the story about the best health care delivery system the world has ever known. Our medical research papers and journals are not read by the average voter either. And, likewise, what the general public knows, feels, and expresses—that's what counts. Too many members of the U. S. Congress appear determined to continue down the road of more government intervention.

The lesson which we in medicine can learn from the space program is apparent. If we are to win the battle for free enterprise, for medicine and for our patients, we must profit from the mistakes of our space program leaders. We must find a way to get the facts to the voters—and what professional man talks to more voters each day than the doctor? The doctor, according to a recent poll, is held in the highest regard by our citizens, and the politician, sad as it is, remains far down the list. It seems incongruous to me that they should be deciding and directing our eventual fate. So Doctor, for your own survival maybe you should begin telling your patients that there is no medical crisis—and no need for PSRO, HMO, or the other alphabetical abortions.

NASA's accomplishments are unbelievable but their ineptitude in telling the story is even more amazing. Doctor, let's not make the same mistake. The alternative might be a similar type of mediocrity which many of our politicians have apparently decreed for the world's finest manned space flight program.



# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions



# Chewable Tablets<sup>500 mg</sup> Mintezol<sup>®</sup> (THIABENDAZOLE | MSD)



so easy to take  
everyone in the family  
can keep to the  
regimen you prescribe

include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.  
**Supplied:** Chewable tablets, containing 500 mg thiabendazole, in boxes of 36, strip packaged, individually foil wrapped; Suspension, containing 500 mg thiabendazole per 5 ml, in bottles of 120 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

## INDICATION | DOSAGE SCHEDULE

MINTEZOL<sup>®</sup> (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infections. Dosages are weight related. For your convenience, the information in the weight-dose chart below is included in the full prescribing information and in the 1973 edition of PDR.

*The recommended maximum daily dose of MINTEZOL is 3 g (6 tablets).*

MINTEZOL should be given after meals if possible. Dietary restriction, complementary medications, and cleansing enemas are not needed.

The usual dosage schedule for all conditions is two doses per day. The size of the dose is determined by the patient's weight.

Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days.  This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

\*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

## **Medical News**

### **Industrial Health Conference**

The Annual American Industrial Health Conference will be held at the Americana Hotel, Bal Harbour, April 28 to May 2, 1974. The Conference includes the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses.

Registration is open to anyone interested in industrial health. Information may be obtained by contacting: Ms. Doris Flournoy, 150 North Wacker Drive, Chicago, Illinois 60606.

### **Florida Gets Thoracic Professor**

Peter Vincent Moulder, M.D., has accepted a joint appointment as Chief of the Thoracic Surgical Service at the Gainesville Veterans Administration Hospital and Professor of Thoracic and Cardiovascular Surgery at the University of Florida College of Medicine.

Most recently, Dr. Moulder was located in Philadelphia, where he was director of surgery at Pennsylvania Hospital and Professor of Surgery at the University of Pennsylvania.

He received his M.D. degree from the University of Chicago.

### **Pathologists Establish Prize**

The Florida Society of Pathologists has announced creation of the Alfred L. Lewis Jr., M.D., Memorial Research Prize in honor of one of its best known members.

The prize is a \$500 award which will be made to a pathology resident in Florida who is judged to have submitted a paper presenting the best original research in anatomical or clinical pathology. In addition, the winner will be invited to present his paper at the annual scientific meeting of the Society.

Entries must be postmarked no later than January 5, 1974, and must be received by the Secretary of the Society by January 8. Information may be obtained by contacting Matthew C. Patterson, M.D., Secretary, Florida Society of Pathologists, St. Vincent's Medical Center, Barrs Street and St. Johns Ave., Jacksonville, Fla. 32203.

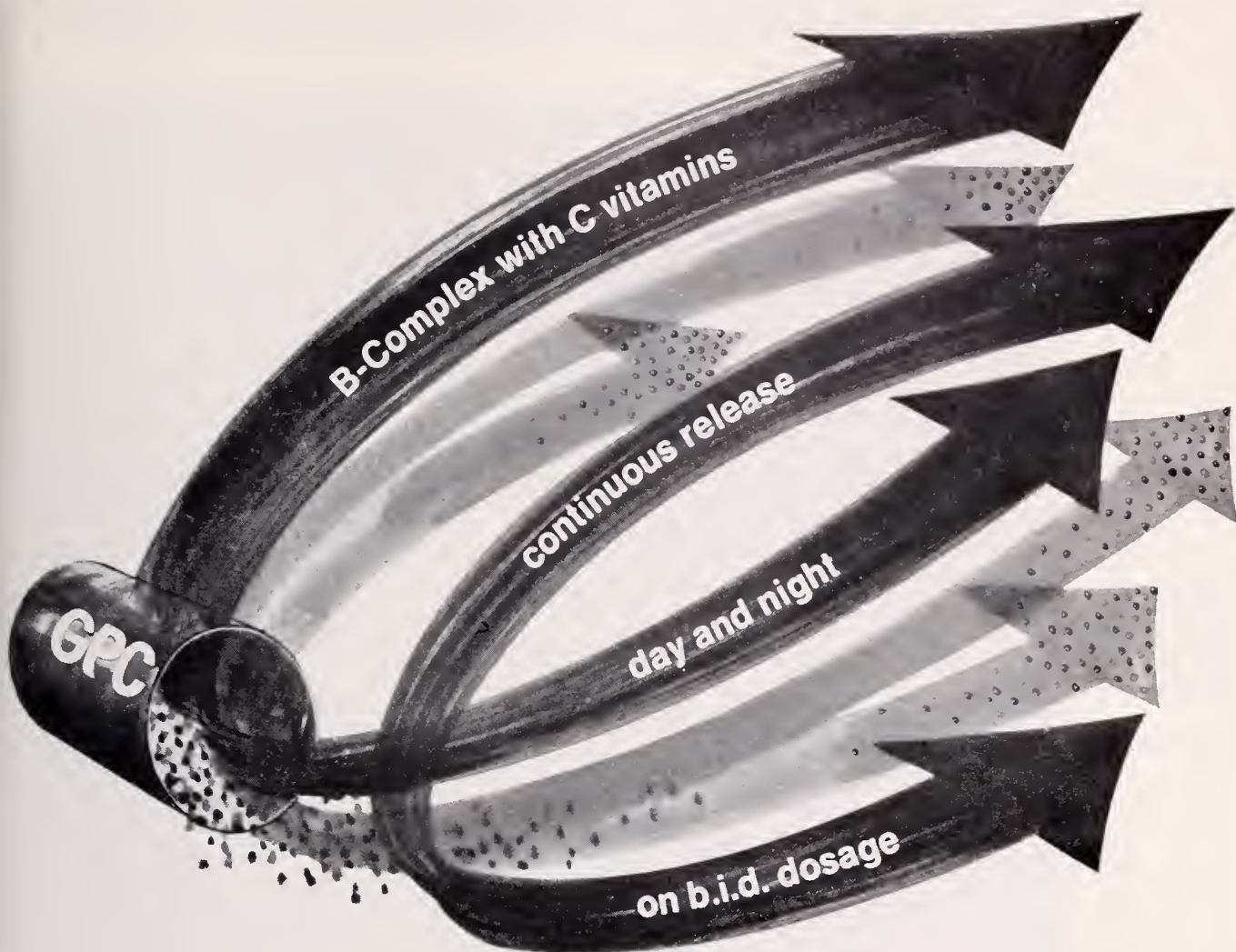
Dr. Lewis, of Tallahassee, was a popular and active member of the Society of Pathologists and the Florida Medical Association. He died in an automobile accident in Tallahassee in October, 1972.

### **Anesthesiologist Elected to Medical Liability Commission**

Recently elected Vice Chairman of a new liability commission, sponsored by the AMA and several other national medical organizations, is J. Gerard Converse, M.D., anesthesiologist from Winter Haven, and Chairman of the American Society of Anesthesiologists' Committee on Professional Liability. The Commission, formed as reaction to the HEW Secretary's Commission on Medical Malpractice, represents a total provider-oriented study and action group to work on the multifaceted problems of professional liability. The Chairman of the MLC is Dr. Charles Hoffman, immediate past president of the AMA, and Mr. Jay Hedgepeth of the American Hospital Association is the Secretary-Treasurer.

On December 1-2, 1973, in New Orleans, the ASA's Committee on Professional Liability is sponsoring a workshop with a distinguished faculty covering many aspects of malpractice problems.





introducing **B-C-BID**  
 B-complex with C  
 an improved delivery system  
 sustained release by micro-dialysis diffusion

New B-C-BID provides a smooth, continuous, predictable rate of release of water-soluble B-complex and C vitamins. Your patient can now *retain more* of these vitamins because tissue levels can now be held much higher than was possible with ordinary formulations.

Wherever B-complex with C is indicated . . . prescribe the product that delivers most efficiently . . . new B-C-BID.



**EACH B-C-BID CAPSULE CONTAINS:**

Vitamin B-1 (Thiamine Mononitrate)	15 mg
Vitamin B-2 (Riboflavin)	10 mg
Vitamin B-6 (Pyridoxine)	5 mg
Niacinamide	50 mg
Calcium Pantothenate	10 mg
Vitamin C (Ascorbic Acid)	300 mg
Vitamin B-12 (Cyanocobalamin)	5 mcg

**DOSAGE:** FOR CONTINUOUS 24 HOUR THERAPY,  
 ONE CAPSULE AFTER BREAKFAST AND ONE AFTER  
 SUPPER. SAMPLES ON REQUEST.

Formula developed and distributed by

**GERIATRIC PHARMACEUTICAL CORP.**  
 FLORAL PARK, NEW YORK 11001

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# Gantanol<sup>®</sup> (sulfamethoxazole) and the

## 0.1 M.I.C. for three hours

Similar elongations  
occur regardless of  
antibacterial used.

## 1.0 M.I.C. for three hours

Similar midcell  
defects seen with  
increased antibac-  
terial concentrations.

## 10 M.I.C. for three hours

Similar spheroplast-  
like forms appear  
with high  
concentrations of  
the antibacterials.



E. coli + sulfamethoxazole



E. coli + tetracycline

## The Scanning Electron Microscope (SEM) reveals the effect

**The *in vitro* experiment.** These SEM photomicrographs were taken as part of a study exploring the effects of various antibacterials with different modes of action on the surface morphology of bacteria. The scanning electron microscope was used because of its ability to show three-dimensional views of organisms, enabling better definition and appreciation of surface morphology.

For this portion of the experiment, *E. coli* were exposed to the following agents: sulfamethoxazole, a chemical drug which acts by interference with para-

aminobenzoic acid utilization; tetracycline, which interferes with intracellular protein synthesis; and cephalothin and ampicillin, which are cell-wall-active drugs.

Strains of *E. coli*, each susceptible to the respective antibacterials, were exposed for 15, 30, 60, 120 and 180 minutes and 18 hours to several concentrations of each agent.

Following the 180-minute or three-hour exposures to the antibacterials at 0.1 M.I.C., 1.0 M.I.C. and 10 M.I.C., photoscans of the *E. coli* were taken. As shown above, regardless of the antibacterial agent used or its mode of action, the changes in surface morphology were remarkably similar... elongation at low drug concentrations, midcell defects at higher



# Three-Dimensional World of SEM



E. coli + cephalothin



E. coli + ampicillin

## of certain antibacterials on bacterial surface morphology

concentrations and ultimate progression to spheroplast-like forms.<sup>1</sup>

**The interpretation.** "At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."<sup>2</sup>

**It should be noted that this information represents only *in vitro* research. No clinical significance can be drawn from this study concerning the effective-**

**ness of any of the agents discussed, as it is not possible to extrapolate *in vitro* data to humans. This information is presented to demonstrate the continuing research activities in the area of antibacterials, particularly modes of action and surface morphology.**

<sup>1</sup>Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

<sup>2</sup>*Antimicrob. Agents Chemother.*, 1:164, 1972.

See next two pages for product information.

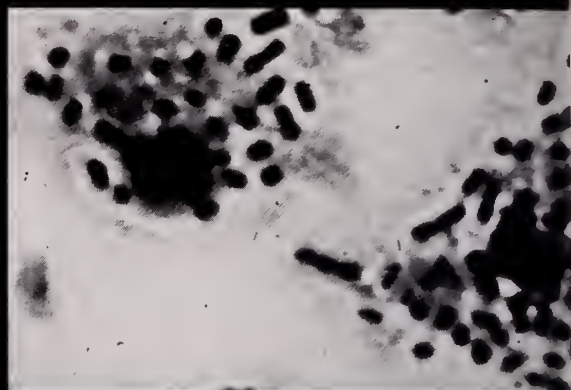


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Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Observations from



*E. coli*—Fluorescent stain



*Klebsiella* sp.—Stain to define capsular envelope

## ■ Effective control of primary susceptible bacterial offenders

Gantanol® (sulfamethoxazole) is effective against susceptible strains of *E. coli*, the most common cause of urinary tract infections. It is also highly effective against other susceptible gram-negative and gram-positive organisms, usually *Klebsiella-Aerobacter*, *Staph. aureus* and *Proteus mirabilis*.

## ■ Prompt antibacterial blood and urine levels—in from 2 to 3 hours

Antibacterial levels of Gantanol usually appear in blood and urine in from 2 to 3 hours after the initial 2-Gm adult dose. This rapid initiation of effective antibacterial activity enables prompt treatment of certain nonobstructed urinary tract infections and may also help avert possible sequelae.

## ■ Around-the-clock coverage for 14 days

Mounting evidence in current medical literature suggests a minimum of 14 days' continuous therapy for certain urinary tract infections.\* Following the initial 2-Gm adult dosage of Gantanol, each 1-Gm dose provides up to 12 hours of antibacterial activity during the treatment period. When urinary tract infection is more severe, *t.i.d.* (q. 8 h.) dosage schedule may be required. Both regimens provide around-the-clock therapy, important because normal urinary retention during sleep tends to favor bacterial proliferation. It is also convenient for patients not to have to take middle-of-the-night medication.

## ■ Also effective in certain nonobstructed chronic and recurrent urinary tract infection

Nonobstructed urinary tract infections, such as cystitis or pyelonephritis—chronic and/or recurrent—develop more commonly in the elderly and debilitated, and response to Gantanol is often highly satisfactory.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-

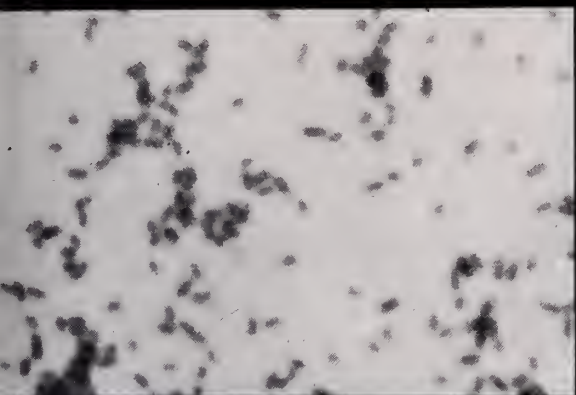
hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

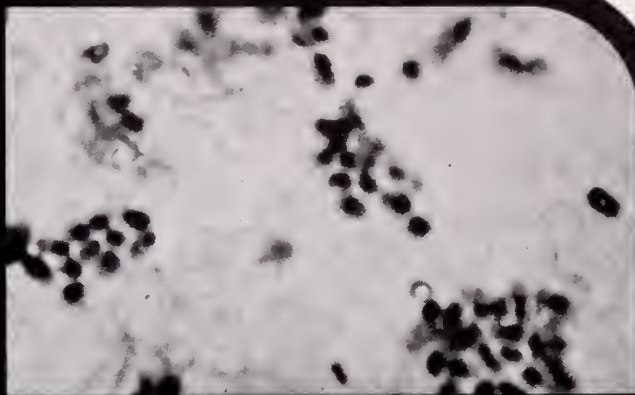
**Adverse Reactions:** Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglo-



# clinical practice



*Enterobacter* sp.—Gram stain showing characteristic gram-negative rod



*Proteus mirabilis*—Flagella stain

## ■ Your option: tablets or suspension

Gantanol Tablets or the pleasant-tasting, cherry-flavored Suspension can provide dependable antibacterial activity to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement usually may be expected to begin within 24 to 48 hours. Usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol is generally well tolerated, with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended during therapy.

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

## Gantanol<sup>®</sup> B.I.D. (sulfamethoxazole) Basic therapy

binemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage:** Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# MEETINGS

## Approved by FMA Committee on Continuing Education

### DECEMBER

- 7-8 Symposium in Perinatology  
Mailman Center for Child Development, University of Miami School of Medicine\*
- 7-8 High Risk Pregnancy and Gynecologic Oncology, South Building Auditorium, Cedars of Lebanon Health Care Center, Miami. For information: Director of Education, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125.
- 10-11 Infant Nutrition for the Practicing Physicians, University of the South Florida College of Medicine, Tampa. For information: Lewis A. Barness, M.D., University of South Florida College of Medicine, Tampa.

### JANUARY

- 2-5 Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Eden Roc Hotel, Miami Beach\*
- 3-6 Eleventh Annual Postgraduate Seminar in Anesthesiology: Cardiovascular System (co-sponsored by the University of Florida, Mount Sinai Hospital of Greater Miami, Florida Medical Association, Florida Society of Anesthesiologists, and South Florida Society of Anesthesiologists) Playboy Plaza Hotel, Miami Beach\*
- 6-10 Neuro-Ophthalmology Seminar  
Sonesta Beach Hotel, Key Biscayne\*
- 7-9 Surgery of the Nose and Paranasal Sinuses  
Rosenstiel Medical Sciences Building, University of Miami School of Medicine\*
- 8-11 Special Procedures in Diagnostic Radiology, Playboy Plaza Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.
- 9-11 International Symposium on "Recent Advances in Clinical Electrophysiology: His Bundle Electrophysiology," Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Frances Richardson, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.
- 9-12 Clinical Diagnosis of Neurological Diseases in Children  
Eden Roc Hotel, Miami Beach\*
- 14-19 Miami Winter Symposia (Biochemistry) Sheraton Four Ambassadors Hotel, Miami\*
- 16-19 Eighth Annual Postgraduate Seminar in Surgery  
Eden Roc Hotel, Miami Beach\*
- 21-25 Hematology 1974—Presented by the American College of Physicians in cooperation with the Department of Medicine  
Sheraton Four Ambassadors Hotel, Miami\*
- 23-27 Pediatric and Adult Urology  
Playboy Plaza Hotel, Miami Beach\*
- 24-26 Infectious Diseases—1974: Treatment and Prevention, Eden Roc Hotel, Miami Beach. For information: Marvin L. Meitus, M.D., 1680 Meridian Avenue, Miami Beach 33139.
- 24-27 Postgraduate Seminar in Pediatric and Adult Urology, Playboy Plaza, Miami Beach. For information: Michael P. Small, M.D., 1200 N.W. 10th Avenue, Miami 33136.

### JANUARY (continued)

- 28-31 Postgraduate Seminar in Neurology  
Sheraton Four Ambassadors Hotel, Miami\*
- 31-Feb. 3 Nineteenth Central Florida Medical Meeting presented by Orange County Medical Society and Seminars and Symposia, Contemporary Plaza Hotel, Disney World. For information: Seminars & Symposia, Inc., Box 1537, Richmond, Va. 23212.

### FEBRUARY

- 2-6 Postgraduate Course in Clinical Allergy  
Sonesta Beach Hotel, Key Biscayne\*
- 4-9 Florida Midwinter Seminar in Ophthalmology and Otolaryngology  
Americana Hotel, Miami Beach\*
- 4-9 Courses of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.
- 17-22 Internal Medicine 1974  
Sheraton Four Ambassadors Hotel, Miami\*
- 22-24 Pediatric Dermatology Seminar, Fontainebleau Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

### MARCH

- 7-10 Skin 1974: Modern Management of Common Skin Disorders—Seminars for the Family Physician  
Playboy Plaza Hotel, Miami Beach\*
- 13-16 Sixth Teaching Conference in Clinical Cardiology  
Sheraton Four Ambassadors Hotel, Miami\*
- 26-30 Radiology in Medical and Surgical Emergencies.  
Playboy Plaza Hotel, Miami Beach\*

### APRIL

- 3-5 "Clinical Nephrology and Heart Disease II," Eden Roc Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.
- 8-12 Ophthalmic Plastic and Corneal Surgery  
Doral Hotel, Miami Beach\*
- 22-27 Courses of Instruction in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami 33152\*

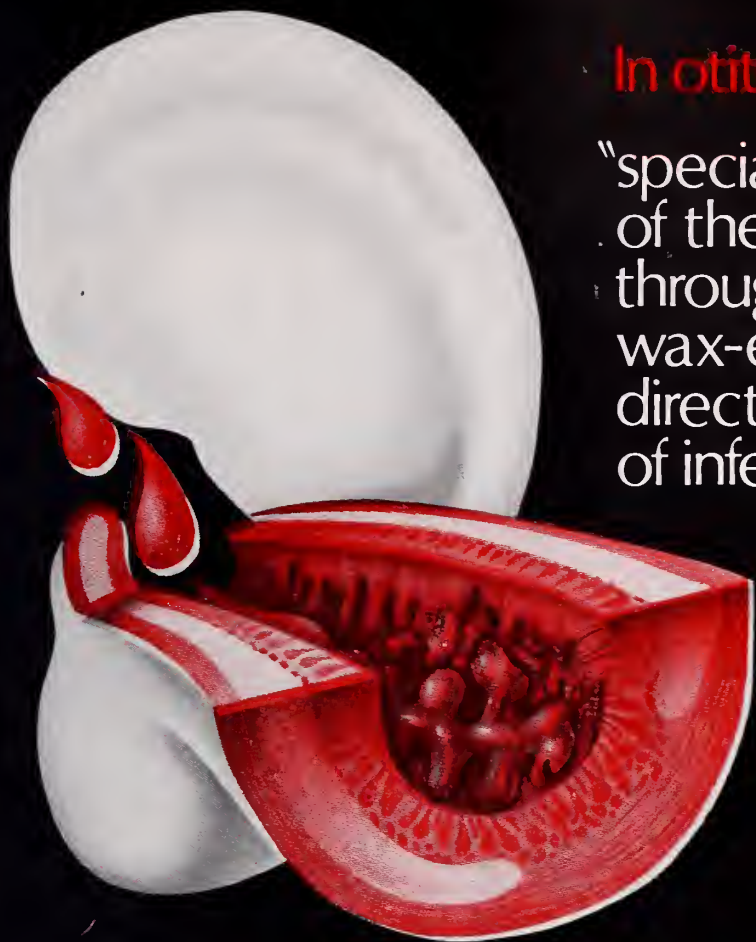
### MAY

- 2-4 Master Approach to Cardiac Emergencies  
Contemporary Hotel, Disney World, Orlando\*
- 4 Intensive Care Symposium (Department of Surgery, University of Miami, in cooperation with the Department of Anesthesiology, University of Florida College of Medicine)  
University of Florida, Gainesville\*

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\*For Information: Contact the Division of Continuing Education University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami. Tel. (305) 350-6716.





In otitis externa...

"special delivery"  
of therapeutic agents  
through the  
wax-exudate barrier...  
directly to the site  
of infection

# Otalgine Drops

(neomycin undecylenate 0.067% ;  
tyrothricin 0.1% ; hydrocortisone alcohol 0.1% ;  
ethylene oxide-polyoxypropyleneglycol  
condensate 1.0% otic solution)

- ☐ Antibiotics to combat susceptible bacteria and fungi
- ☐ Antifungal action of the undecylenate salt of neomycin against *Aspergillus* and *Monilia*
- ☐ Hydrocortisone to reduce inflammation and pruritus
- ☐ Surfactant-penetrant to deliver therapeutic agents directly to the infected area

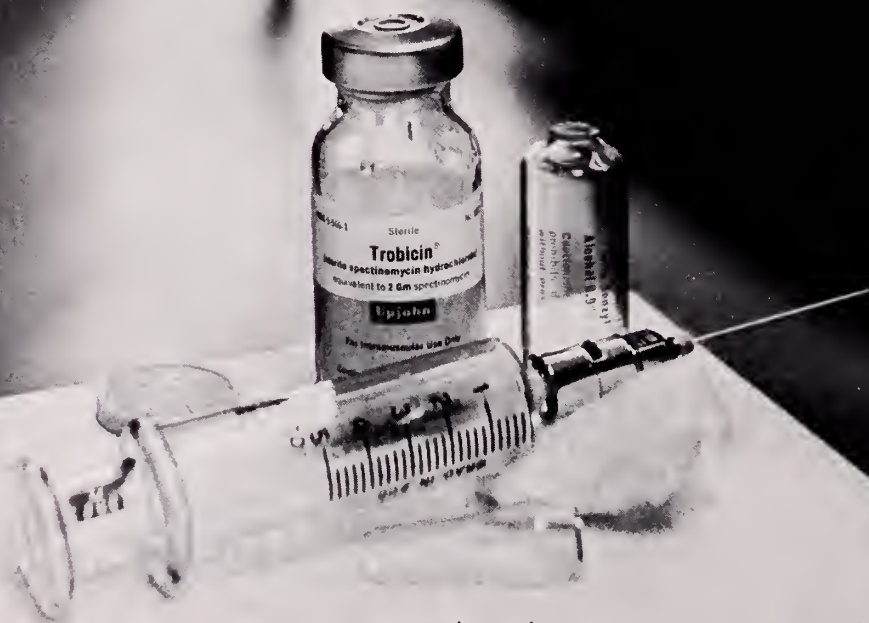
Penetrating the barrier of wax and exudate, OTALGINE Drops bring antibiotics and steroid directly into contact with the infected tissue, with gratifying results against major otic pathogens, including *Pseudomonas aeruginosa*, *Aspergillus* and *Monilia*. In clinical trials, "Good" to "Excellent" results were reported in 87.8% of 886 cases of otitis externa with 1,149 affected ears.\*

**BRIEF SUMMARY:** **Indications:** All indications are predicated upon infections due to organisms susceptible to neomycin or tyrothricin, or to the undecylenate salt of neomycin. Otitis Externa (acute and chronic)—Fungal infections (such as *Monilia* and *Aspergillus*). **Contraindications:** Tuberculous and most viral lesions (herpes simplex, vaccinia, and varicella particularly); less common fungal infections (other than *Monilia* and *Aspergillus*); hypersensitivity to any of components. **Precautions:** Use with care in cases of perforated eardrum or long-standing otitis media because of possibility of ototoxicity. As with all antibiotics, prolonged use may result in overgrowth of non-susceptible organisms. If superinfection occurs, appropriate measures should be instituted. There are reports in medical literature indicating increased incidence of persons sensitive to neomycin. **Side effects:** Apparent allergic reactions with such symptoms as crusting, swelling, vesicular rash of the external canal or increase in discharge reported in 1.2% of patients treated; transient warmth or burning sensation on instillation, in 2.7%. **Dosage:** 2 to 5 drops, b.i.d. to q.i.d., or the wick method, with the wick moistened b.i.d. to q.i.d., until disease has cleared or become static. **NOTE:** Refrigerate until dispensed. After opening, keep at room temperature; unused contents should be discarded after 14 days. \*BIBLIOGRAPHY AVAILABLE ON REQUEST.

# acute gonorrhea

This patient  
just received  
an effective, private,  
physician-controlled  
treatment.

It took just one short visit...



\*Urethritis, cervicitis, proctitis when due  
to susceptible strains of *N. gonorrhoeae*



### **Trobicin—The advantage of injectable therapy.**

Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

### **Trobicin—The aspect of privacy.**

There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

### **Trobicin—Indication and dosage.**

Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly<sup>†</sup>; 4 grams intramuscularly in females.

### **Trobicin—Not effective for syphilis.**

Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

# ...and **Trobicin**<sup>®</sup> 2 gm and 4 gm vials sterile spectinomycin hydrochloride

#### **Sterile Trobicin**

*Sterile Trobicin (spectinomycin hydrochloride)*  
—For Intramuscular Injection:

2 gm vials containing 5 ml when reconstituted with diluent.

4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to spectinomycin.

**Warnings:** Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of

syphilis is suspected.

*Safety for use in infants, children and pregnant women has not been established.*

**Precautions:** The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

**Adverse reactions:** The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25° C and use within 24 hours after reconstitution with diluent.

**Male—Inject 5 ml intramuscularly for a 2 gram dose.** Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

**Female—Inject 10 ml intramuscularly for a 4 gram dose.**

**How supplied:** Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only. **Susceptibility Powder**—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

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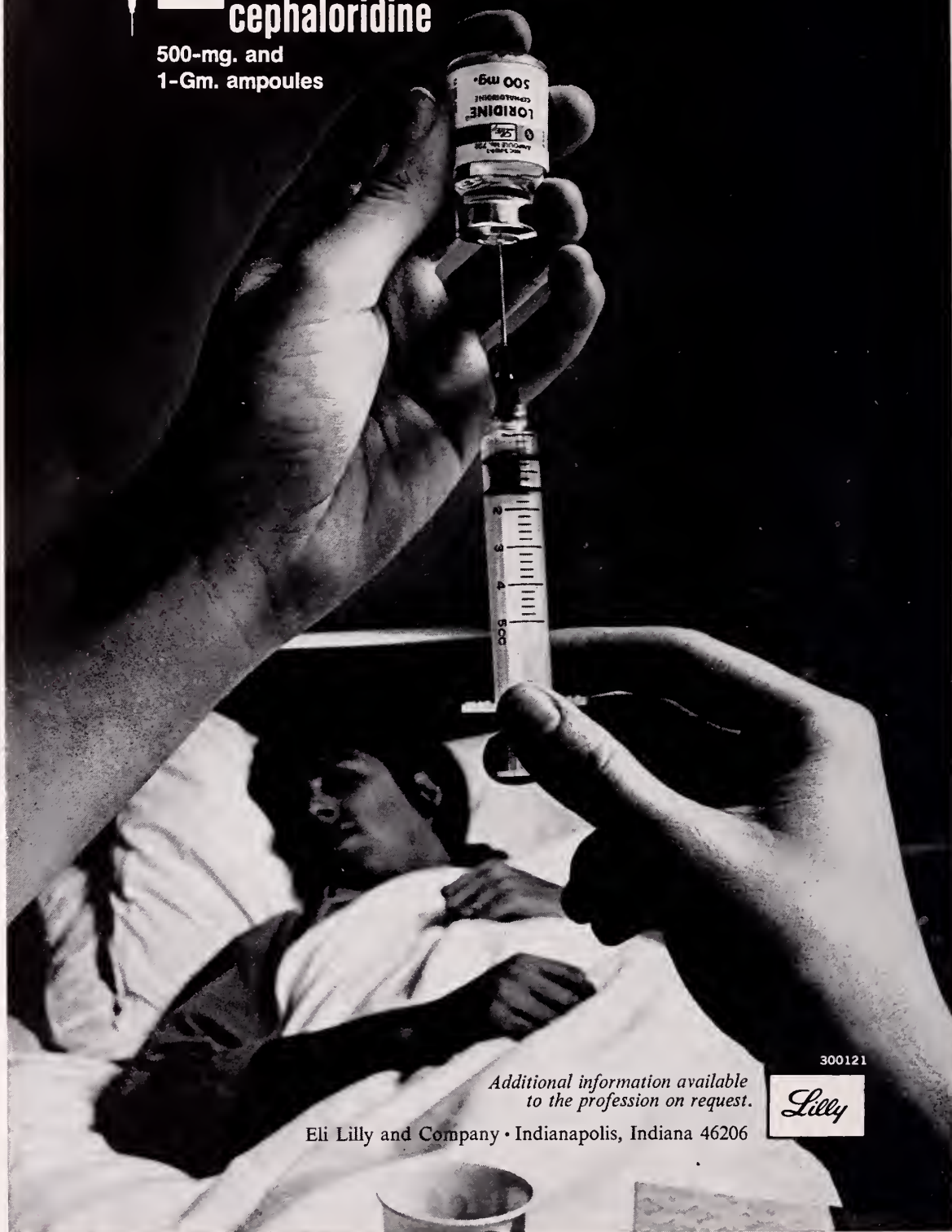
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<sup>†</sup>For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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## Changes in Vision and Recovery of Macular Function After Scleral Buckling

### A Study of 478 Consecutive Cases

NEIL F. LETTS, M.D.

**Abstract:** In the series of patients studied, vision recovery after macular reattachment followed an asymptotic curve. However, "plateaus" or areas of flattening of the recovery curve followed by accelerated recovery of vision were related to macular edema, exudates and pucker. In many eyes subjected to scleral buckling without preoperative macular separation, there was a temporary decrease in vision of uncertain etiology nature and subsequent recovery to preoperative levels by five months. Age, aphakia, duration of preoperative symptoms and operative factors were analysed for effects on vision recovery but insufficient data was available. Half the patients achieved best recorded vision within 18 months following surgery but 20% required more than 30 months to achieve best vision. Less severe preoperative vision loss appeared to favor more rapid attainment of and an improved likelihood of better postoperative vision. Patients with 20/100 or less best-recorded vision postoperatively were excluded from this study.

postoperative vision change were studied in these patients including (1) the effect of preoperative vision on postoperative recovery rate and final vision, (2) normal recovery patterns following reattachment of the separated macula, (3) vision changes following scleral buckling in cases where the macula was not detached, (4) abnormal recovery patterns following reattachment of the macula, (5) effects of duration of symptoms, age, aphakia, subretinal fluid drainage, extent of specific quadrants detached and buckled, use of supplementary photocoagulation on rate of recovery and final visual result.

Of the 478 patients, 442 consecutive ones with pre- and postoperative recorded visual acuities were selected on the basis of achieving at least 20/80 vision after scleral buckling. These were divided into groups by best recorded visual acuity (Fig. 1) and subsequently into additional groups on the basis of preoperative vision 20/100 or less and 20/80 or better to give a crude comparison of rates of visual recovery related to preoperative visual status (Figs. 2-5). Out of the 442 patients only 83 had sufficiently clear vision recovery patterns which might satisfactorily demonstrate the typical pattern after separation of the macula. In order to demonstrate "the way" in which macular function returned after separation, they were divided into "fast," "intermediate" and "slow" recovery groups on the basis of final

This paper is concerned with visual recovery patterns following retinal separation in 478 patients who achieved at least 20/80 vision after successful scleral buckling. Several aspects of

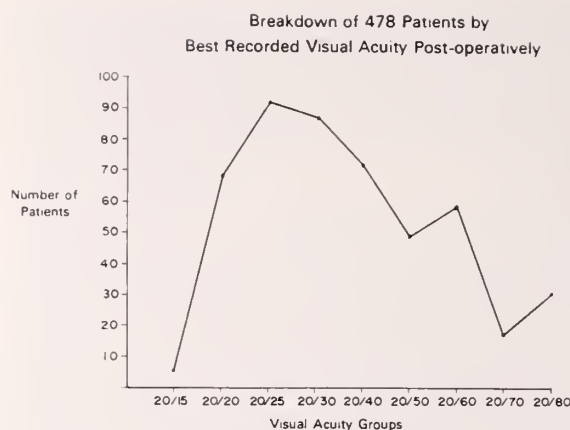


Fig. 1.—Distribution of cases on basis of last recorded vision.

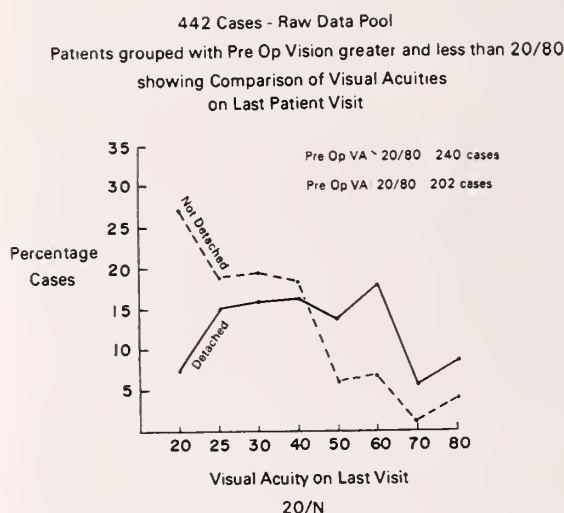


Fig. 2.—Influence of preoperative vision on postoperative vision.

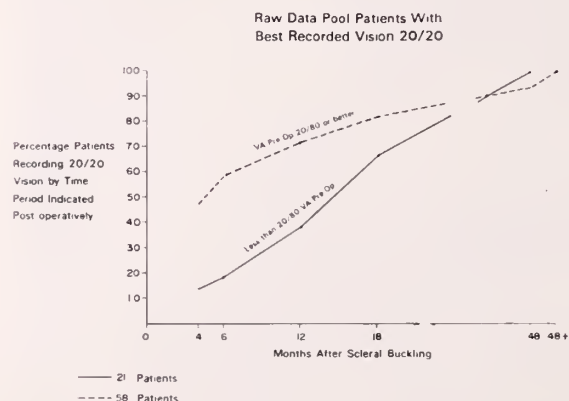


Figure 3

Figs. 3-6.—Influence of preoperative vision on rate of recovery of vision.

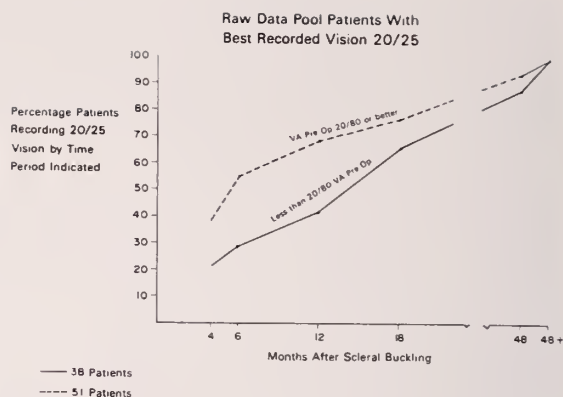


Figure 4

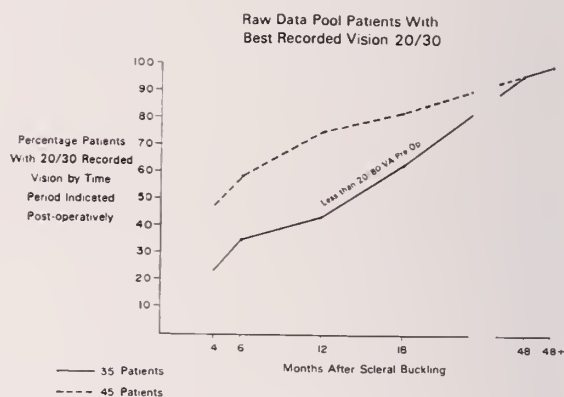


Figure 5

recorded vision of 20/20-30, and also best recorded vision after 21 months of 20/40-70. The "fast" group included all patients with 20/30 or better vision achieved in eight months or less; the "intermediate" group, those in the same range achieving the acuity between 9-21 months and the "slow" group, those achieving 20/30 or better vision beyond 21 months. Cryotechnique along with scleral resection and solid silicone implants were used almost universally in the series studied.

The 83 patients were subjected to analysis to determine if age, duration of visual symptoms, drainage of subretinal fluid, supplementary photocoagulation, aphakia, number and specific quadrants detached and buckled were factors affecting rate of recovery and final vision obtained.



## Results

Figure 1 shows the numerical distribution of all 478 cases grouped by best recorded visual acuity. The resulting curve demonstrates that in the overall group destined to achieve 20/80 or better vision at least half achieved 20/30 or better vision. Figure 2 demonstrates generally poorer best recorded visual acuity in the patients with presumptive detachment of the macula preoperatively as demonstrated by vision 20/100 or less. This is most marked in the 20/20 level and in the 20/50 or below range. Figures 3-6 show the percentage cases recording the best vision. It is higher in the earlier postoperative period in those cases in which the preoperative visual acuity was at least 20/80, i.e., comparison of the curves suggests that final visual acuity is more quickly achieved when macular function is less interfered with preoperatively.

Figures 7-10 represent the asymptotic vision recovery curves in each of the groups and are presented to give examples of "the way" in which vision recovers after detachment of the macula. It is of interest that Figure 9 shows a departure from the typical asymptotic curve which is, however, found again in the slower recovery group (Fig. 10).

Figure 11 shows that 23 out of 60 cases without preoperative macular separation had a temporary decrease in visual acuity. Factors which may account for the decrease include refractive change, ptosis, hypertropia, symblepharon, pucker at or near the macula, edge of detachment near the macula, retina more than 50% detached, vitreous haze, and hypotony, which were found in various patients studied.

Figure 12 shows examples of the "plateau phenomenon," i.e., breaks in the normally asymptotic curves apparently related to macular edema and/or pucker.

In the group of 19 patients achieving a "final" visual acuity of 20/40-70, a significant incidence of macular changes of more permanent nature was noted whereas none of these changes appeared in the final 20/20-30 group. In the "final" 20/40-70 group, two macular holes were seen, two patients had vitreous traction involving the macula, one a myopic conus, and six showed pigment clumps at the macula.

In the 83 patients studied to determine if age, duration of detachment symptoms, aphakia and operative factors were responsible for variations

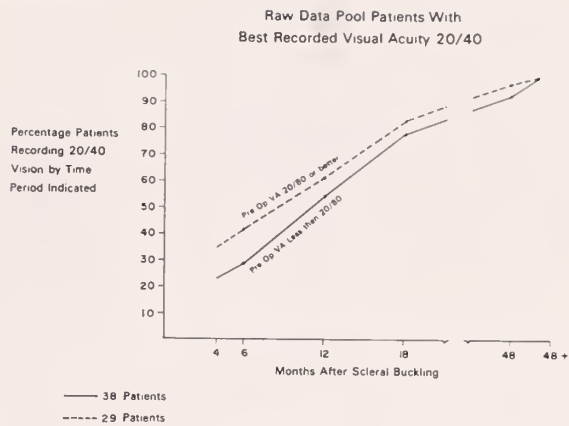
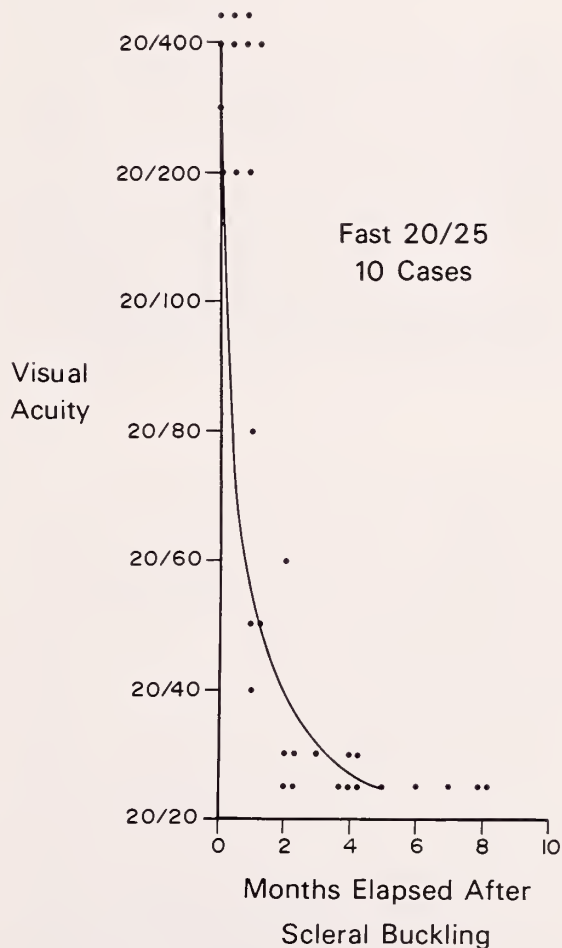


Figure 6



Figs. 7-8.—Normal asymptotic recovery patterns.

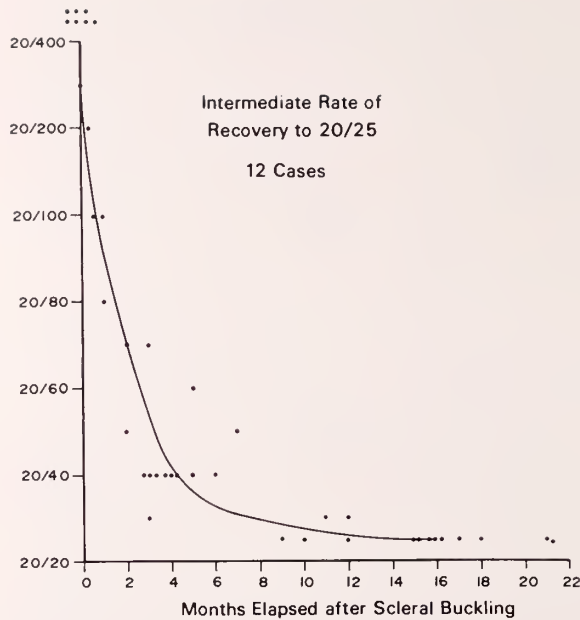


Figure 8

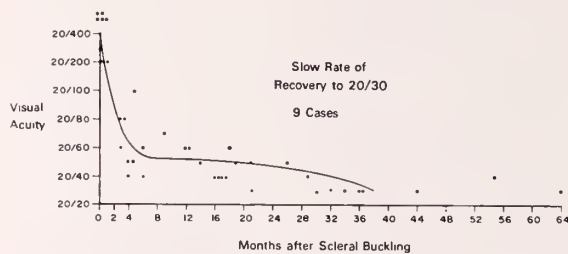


Fig. 9.—Interruption in normal recovery pattern after which vision shows accelerated improvement.

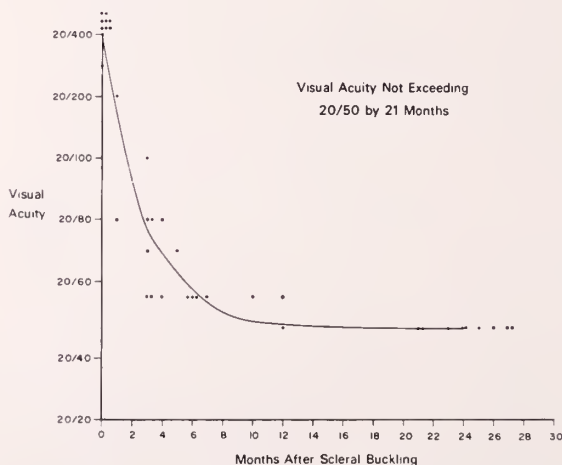


Fig. 10.—Asymptotic recovery pattern to final reduced acuity level.

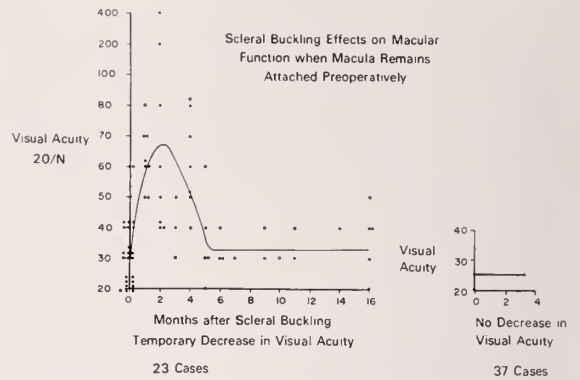


Fig. 11.—Temporary decrease in vision in 23 out of 60 cases even though macula is not detached preoperatively. All returned to preoperative level by five months.

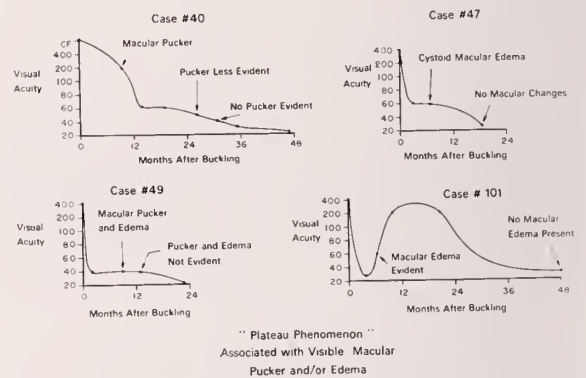


Fig. 12.—Four cases displaying temporary effects of pucker and edema on visual recovery.

in rate of recovery and final visual result, with the data available, there is no suggestion that any of the factors considered separately have any influence. However, no statistically valid statement can be made on the basis of the amount of data available.

## Discussion

Kronfeld<sup>1</sup> reported studies of visual function in six patients after retinal reattachment with diathermy and drainage.

Curtain<sup>2</sup> et al reported 12 cases of aniseikonia after retinal reattachment with diathermy and drainage and noted minification of the image in the involved eyes.

Hughes<sup>3</sup> reported the results of 375 cured cases of primary retinal detachment with at least



six months follow-up. He found that one third of patients in his series with preoperative visual acuity of 20/200 or less achieved 20/40 vision or better postoperatively. Also, that no patients with a history of detachment six months or greater preoperatively achieved 20/40 or better vision. He reported a 67% overall cure rate in his series preceding the scleral buckling era.

Braley and Ostler<sup>4</sup> in 1955 reported the visual results of 100 patients receiving diathermy and drainage for retinal separation. In the successful cases, 84% achieved 20/70 or better vision (11 out of 14 aphakic cases and 46 out of 54 phakic cases) and 56% achieved 20/40 or better vision. Of interest is the overall cure rate of 68% in their series. However, no mention of the preoperative status of the macula is made.

Givner and Karlin<sup>5</sup> reported a case of astigmatism after scleral buckling which lessened after seven months. Rosenthal<sup>6</sup> reported the retinoscopic findings in 162 patients after scleral buckling and noted hyperopia with astigmatism which disappeared in most cases by the end of six months. He also noted that aphakic patients appeared to display little refractive change after scleral buckling.

Norton<sup>7</sup> reviewed his findings in 424 cases from 1955-1960 with at least six months follow-up. He found 87% of patients with at least 20/50 vision preoperatively retained at least 20/50 vision postoperatively and that 30% of patients with 20/70 or less vision preoperatively showed 20/50 or better vision postoperatively. Forty-four percent of his aphakic and 54% of his phakic patients obtained 20/50 or better vision postoperatively. Thirty-eight percent of his patients with macular detachment preoperatively achieved 20/50 or better vision whereas 84% with no preoperative macular detachment achieved 20/50 or better vision. Comparing patients with less and greater than two months duration of detachment preoperatively, Norton found 47% of the former and 19% of the latter group achieved 20/50 or better visual acuity.

Grupposo<sup>8</sup> studied 105 eyes after scleral buckling with solid silicone implant and encircling element with scleral dissection. He compared vision before and after operation and concluded that the degree of visual impairment prior to operation is an important index of recoverable postoperative vision but that low preoperative visual acuity does not necessarily preclude good postoperative acuity. In Grupposo's series, best visual acuities were

determined in the period 2-29 months. Within this group the majority of patients best recorded visual acuity lay in the period of 3-13 months and 50% had their best recorded visual by eight months. Spherical refractive changes were noted more commonly than cylindrical changes and tended to be (in contrast to Rosenthal) in the direction of increased minus or decreased plus corrections.

The present study was intended to determine, if possible, the nature and variability of visual changes following scleral buckling procedures. This goal was achieved in 143 patients who were highly selected. Secondly, an attempt was made to determine if operative factors plus age, aphakia and duration of symptoms before detachment were individually responsible for subtle differences in recovery rates and final visual result. Unfortunately, being highly selective of patients resulted in an insufficient data pool to establish results with statistical certainty. However, this does suggest that none of the factors are in themselves powerful enough to significantly alter final visual acuity or rate of recovery.

It did appear from the initial data selection process that multiplicity of reattachment procedures on a given eye will usually result in vision 20/100 or less. It was also apparent that final vision in the range 20/40-70 was often accompanied by permanent macular changes of visible nature such as thinning or lamellar hole formation. Changes noted to affect rate of recovery included (apparently reversible) macular edema and pucker of small degree which, in most cases, caused a flattening of or plateau in the visual recovery curves.

### Summary

Visual changes and factors influencing them were studied in 478 patients receiving scleral buckling procedures who achieved at least 20/80 postoperative vision. Better vision was achieved more quickly in those patients with preoperative vision greater than 20/100. In patients with macula attached preoperatively, 38% demonstrated a temporary decrease in acuity which returned to preoperative levels within six months. Multiple factors may be responsible for the temporary vision reduction. Eighty-three patients with established macular separation and clearly defined recovery patterns were evaluated to show typical and atypical recovery patterns. Inconclusive data failed to indicate that operative factors, age, duration of symptoms and aphakia

had an influence on rate of recovery or final visual result. Reversible macular changes (pucker, edema) caused flattening of recovery curves whereas permanent holes or thinning resulted in many cases in visual reduction to the 20/40-80 level.

### Acknowledgements

Particular appreciation is expressed by the author to Alice R. McPherson, M.D. for her support and allowing access to records of the patients included in this study. Mr. Harold Fish of Boston deserves special credit and appreciation for subjecting the data to statistical analysis.

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## MEDICINE BY REMOTE CONTROL

Medical schools in the U.S. are in turmoil. Bombarded by gratuitous admonition, and urged to take in extra students at the same time as their funds are being cut by the government, an aura of neurotic impotence prevails. No one knows where to go or how to get there, and the same ambivalent feelings apply to the problem-oriented medical record. This method of writing a medical history was introduced by Dr. Lawrence Weed. An evangelist himself, he has elicited the support of Dr. Willis Hurst of Emory University, and between them they are conducting a Madison Avenue campaign to popularise the problem-oriented record which completely overshadows the efforts of the average politician running for office. The latest contents of certain British journals show that Drs. Weed and Hurst already have their converts across the Atlantic. But a mild-to-moderate reaction is taking place in the U.S., and not before time. To be asked to consult on a patient because of problem number 8 seems to be a bit too impersonal. Weed's concept of a problem list, data base, etc., is really nothing new. Any good, orthodox history always contains a summary of the patient's complaints and his diagnoses (now known as problems), and also a series of recommendations based on the history, examination, and laboratory investigations.

Over the past twenty years there has been a marked decline in the ability of U.S. medical students to express themselves both verbally and on paper. Examinations nowadays are all of the multiple-choice type, and this applies to high school, college, and medical school. Most medical

students have never had to write an essay in their life. To organize and put down on paper a logical and concise medical history is often a task beyond their powers, and here the problem-oriented record is without doubt a help. But it seems a poor substitute for what should be an integral part of their education.

Part of the popularity of the problem-oriented record can be traced to the fact that it can be more easily "computerised," and indeed this is one of the arguments that Weed uses in its favour. To facilitate the computerisation of records, after a patient has been registered, many hospitals and clinics ask him to complete a long questionnaire which records physical and mental symptoms, and also his past, family, and social histories. In some instances the questionnaire is sent to the patient for completion before his appointment in the outpatient department. Only when he has completed the questionnaire and has had his routine laboratory tests does he get a chance to see a doctor, and then often all too briefly. And thereby hangs a tale, for the American public is sick of medicine by computer and remote control, and of the unavailability and inaccessibility of physicians. This was brought home to me most forcefully by a patient of mine who is a professor of English. Thrusting his untouched questionnaire at me, he came out with the cryptic comment: "I came to see you, not to complete a damned gallup poll run by a Kinsey-oriented group of behaviourists." I hope he believed me when I said I had nothing to do with the introduction of the ritual.

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# Reye's Syndrome

STANLEY I. MUSIC, M.D., STANFORD T. SHULMAN, M.D., ELIA M. AYOUB, M.D.

AND LAWRENCE B. SCHONBERGER, M.D.

**Abstract:** Reye's Syndrome, encephalopathy with fatty degeneration of the viscera, is a highly fatal, poorly understood condition. Etiology is not known; epidemiology is confused. Centralized case management coupled with systematized data accumulation are suggested means for needed new knowledge.

The syndrome of acute childhood encephalopathy with fatty degeneration of the viscera was first brought to general medical attention by R. D. Reye and co-workers in 1963.<sup>1</sup> Since then over 400 cases have been reported. Characteristically there is a mild prodromal illness consistent with that of a probable viral infection, commonly nasopharyngitis, which is followed within a few days by vomiting and drowsiness. Rapid neurologic deterioration consisting of disorientation and deepening coma generally develop within 48 hours of the onset of vomiting. Death occurs in approximately 40-60% of cases. Laboratory findings in serum include markedly elevated SGOT, increased ammonia, prolonged prothrombin time but a normal to only slightly elevated total bilirubin. Metabolic acidosis and respiratory alkalosis are often present. Despite the apparent clinical encephalitis, there is minimal or no cerebrospinal fluid pleocytosis. Hypoglycemia and hypoglycorrachia are common, particularly in patients under five years of age.

Uniform autopsy findings include edema without inflammation in the brain and fine cytoplasmic lipid deposits without extensive necrosis in the liver. Fatty accumulation may be found also in

the kidney and occasionally in the myocardium and pancreas.

Though controversy exists over the effectiveness of specific modes of therapy, such as glucose-insulin, peritoneal dialysis and exchange transfusions, there is general agreement that early close monitoring of respiratory function, serum glucose, and fluids is indicated. Steroids and osmotic diuretics are often used in an effort to control cerebral edema.

No specific cause for this devastating illness is known. Most patients are under ten years of age and there is no sex preponderance. Epidemiologic studies have documented case clusters or epidemics of Reye's syndrome occurring concurrently with outbreaks of influenza B.<sup>2,3</sup> An association of Reye's syndrome with varicella zoster infection has been recognized in a large number of patients, many of whom showed evidence of encephalopathy approximately four days after the onset of the rash.<sup>2,4</sup> Sporadic associations with other viruses, including Coxsackie A and reovirus, have been reported.<sup>5,6</sup> These associations and the characteristic history in Reye's syndrome of a preceding viral-like illness suggest that this disorder may result from an unusual host response to a number of different viral infections.

Exogenous toxins may play an etiologic role in Reye's syndrome. Contamination of foodstuffs with aflatoxin (produced by the fungus, *Aspergillus flavus*) has been implicated in the marked seasonal variation and relatively high yearly incidence of cases of encephalopathy and fatty degeneration of the viscera in northeastern Thailand.<sup>7</sup>

Despite considerable interest in some quarters, familiarity with Reye's syndrome is still limited, perhaps due in part to failure of recognition. It is not a reportable disease in Florida or elsewhere in the United States and little background data providing long-term incidence or attack rates exist. Recently three cases of Reye's syndrome came to the attention of the pediatric unit at Shands Teaching Hospital, University of Florida College

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of Medicine. The cases occurred over a two-week period in widely scattered areas of the state. Evaluating these cases brought out the desirability of better reporting and a more coordinated study of Reye's syndrome in Florida. Undoubtedly, there is much to be learned.

Currently, appropriate directions in the pursuit of new knowledge of Reye's syndrome in Florida might include the following: (1) Establishing a few centrally located referral centers for cases of Reye's syndrome, such as Florida's three medical schools, so that laboratory studies and collection of epidemiologic and clinical information can be better coordinated; (2) Reporting cases of Reye's syndrome routinely to the Florida Division of Health so that time-space clusters of the illness

can be recognized and investigated epidemiologically.

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## The Killers—Inborn Genetic Defects

PBS-TV—December 17

8:00 p.m. - 9:30 p.m.

The statistics cannot convey the heartbreak: approximately seven percent of all Americans suffer from a genetic defect of some kind; millions more carry genes that cause these defects; an estimated 25 percent of all hospital admissions are related to a genetic defect.

Should screenings for a disease in a fetus be mandatory? If so, must the mother opt for abortion? Do you tell a pregnant woman and her husband they are carriers of sickle cell anemia and there is a one in four chance their child will have this serious disease, even though nothing can yet be done about it?

Many genetic diseases can be called "ethnic." For example, sickle cell anemia, originally an immunity factor against malaria, is a disease that primarily afflicts blacks whose origins lie in Africa. Cooley's anemia, or thalassemia, strikes persons of Mediterranean descent, with incidence highest among Greek and Italian Americans in the

U.S. Tay Sachs disease is a killer of Jewish children of Eastern European ancestry, whereas cystic fibrosis attacks persons whose ancestors came from Western European countries. In fact, virtually everyone is a potential carrier of from five to eight diseases and pre-disposition has been cited as important in a number of diseases, such as diabetes, cancer, heart disease and mental disorders.

Scientific and medical advances in diagnosis and, in some cases, treatment of genetic diseases have been made. But the moral and ethical problems cannot be left in the hands of scientists alone.

The role the individual and the community can play in regulating and improving methods of screening and treatment of genetic disorders is considered in the Inborn Genetic Defects program in "The Killers" series.

Watch for this program on your local PBS-TV. The date and time schedule may vary locally.



# Stereotaxic Radiofrequency Lesions for Trigeminal Neuralgia

ALBERT L. RHOTON JR., M.D.

**Abstract:** Radiofrequency stereotaxic lesions offer an acceptable alternative to other surgical procedures for trigeminal neuralgia. Radiofrequency stereotaxic gasserian ganglion and sensory root lesions overcome the need for prolonged general anesthesia and major surgery. In a series of 18 patients, the method had the expected low morbidity and mortality attendant of a radiologically controlled percutaneous procedure. All patients obtained relief of their pain and no patient has had a recurrence of pain since the first procedure was done two years ago.

Trigeminal neuralgia, the excruciating paroxysmal facial pain provoked by facial stimuli, confined to the trigeminal zone, and not associated with sensory loss can be relieved most permanently by denervation of the painful area. Partial sensory root section by either the subtemporal or suboccipital surgical approach utilizing general anesthesia is the most frequently used pain relieving operative procedure. The characteristic elderly age of those afflicted, high incidence of associated medical conditions complicating the general anesthesia risk and possibility of surgical injury of the facial or extraocular nerves have prompted the search for other means of treatment.

When medical therapy fails and when the patient, for medical or other reasons, is not thought to be a satisfactory candidate for a major operative procedure, peripheral neurectomy and alcohol injections have been tried. Both give only temporary relief lasting an average of 8-16 months because the lesion, being peripheral to the ganglion, allows the nerve to regenerate. Radiofrequency stereotaxic gasserian ganglion and sensory root lesions overcome the need for general anesthesia and major surgery, and because the lesion is

in the ganglion and posterior root rather than in the peripheral branches, the likelihood of recurrence of the pain is reduced. Other surgical risks not present with the radiofrequency stereotaxic procedure are injury to the cavernous sinus, internal carotid artery, and other cranial nerves.

The procedure is facilitated by mild sedation using Innovar. A small amount of Xylocaine is infiltrated 2 cm. lateral to the corner of the mouth of the affected side, if the goal is relief of 3rd division neuralgia and 3 cm. lateral for 1st and 2nd division neuralgia. (Fig. 1.) With the head hyperextended and rotated to the opposite side, the foramen ovale is identified using the image tube. The needle is then directed into the foramen ovale. At this point, the patient usually experiences trigeminal pain. Lateral x-rays are used to determine needle depth. The depth the electrode has passed through the foramen ovale determines the divisional analgesia (Fig. 2). The average depth from the inner aspect of the foramen ovale to the opening of Mechel's cave into the posterior fossa is 2.1 cm.<sup>1</sup> When the needle is in place, a stimulating current is passed through it, and the needle positioned until the paresthesias produced by stimulation are in the area of the trigeminal neuralgia. Twenty or 30 mg. of Brevital, an amount yielding 2-3 minutes of general anesthesia, is then given intravenously. During this period, the lesion is made at 80-85°C for 60 seconds. The patient is then allowed to awaken, and is asked if there is any sensory loss in the face. Sensory testing is done to determine the extent of the analgesia. If the analgesia is not as extensive as desired, the patient is again anesthetized for a brief period. Once the desired result is achieved, the needle is removed, and the patient is sent to the recovery room. Some patients required four or five brief periods of electrocoagulation to obtain the desired facial analgesia. The patient is dismissed the next day.

From the Division of Neurological Surgery, University of Florida College of Medicine, Gainesville.

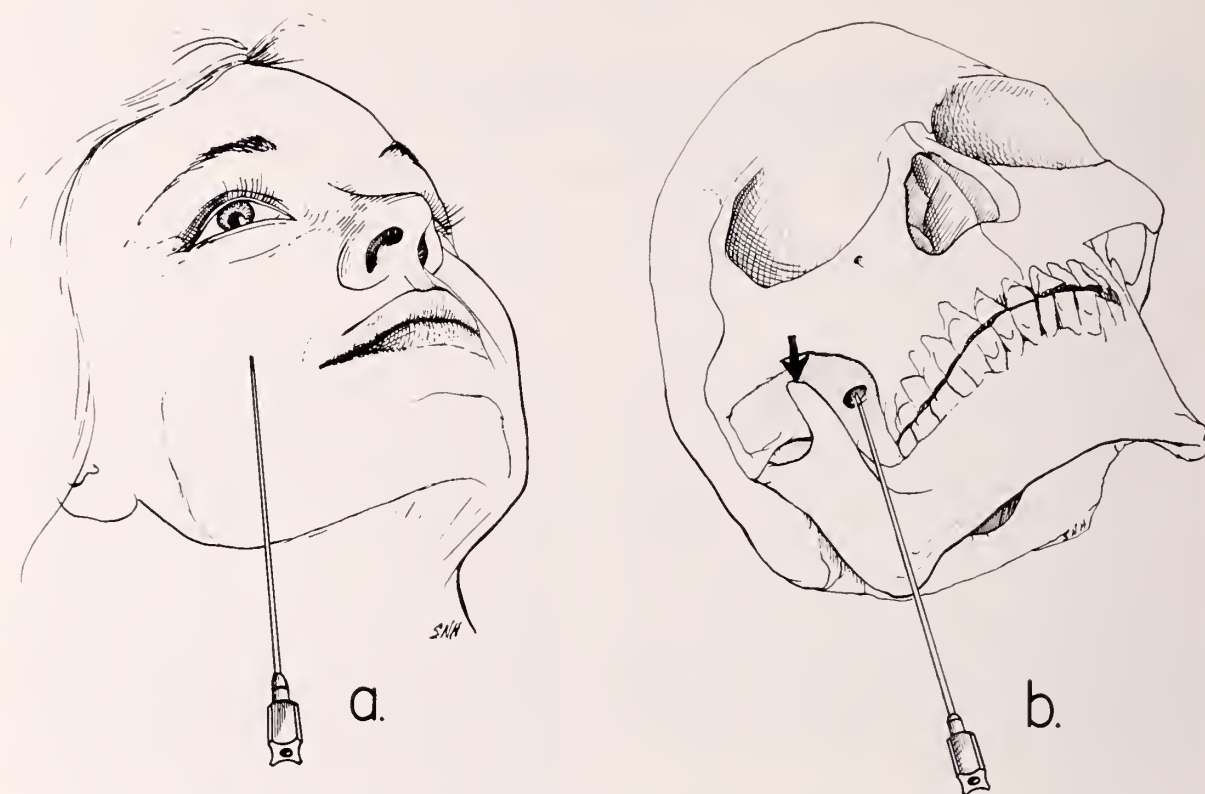


Fig. 1A. Placement of electrode lateral to mouth. B. Electrode inserted to the area of the foramen ovale.

### Results

To date stereotaxic radiofrequency lesions for trigeminal neuralgia have been done on 18 patients. All obtained relief of pain and none have had a recurrence since the first procedure was done two years ago. Three of the patients had classic subtemporal craniectomy and middle fossa approaches for 5th nerve sections previously with recurrence of pain. Fourteen patients had trigeminal neuralgia in the 2nd or 3rd divisions, three in the 1st division and one in all three divisions. There have been no complications from the procedure. The only undesirable feature was extension of the numbness beyond the confines of the involved division in three patients. All patients were dismissed from the hospital one or two days after the procedure.

### Discussion

A large series of patients have been treated in Europe by electrocoagulation over the past three and one-half decades with steady improvement both in technique and results.<sup>2</sup> Results have



Fig. 1C. AP x-ray taken with head turned slightly to the opposite side as shown in A and B. Foramen ovale (horizontal arrow) with inserted needle. Vertical arrow (B&C) on coronoid process of mandible.



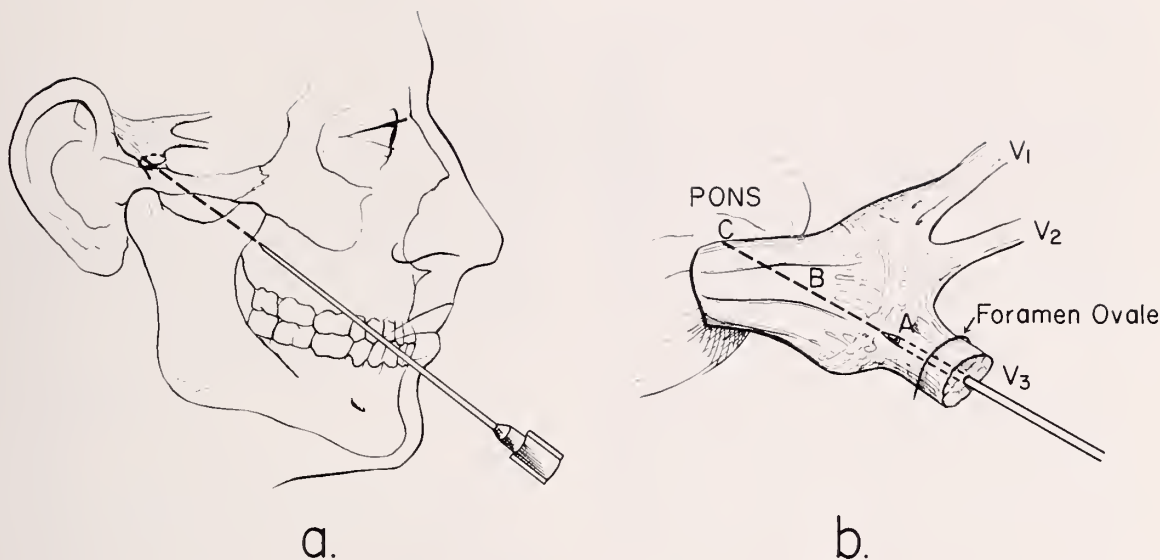


Fig. 2A. Lateral view of placement of electrode. B. Illustrates how advancing the electrode alters the divisional analgesia produced with the lesion. Third division analgesia is produced with the electrode near the foramen ovale (A); second division analgesia with the needle in an intermediate position (B) and first division analgesia is obtained with needle at C.

been improved by using brief periods of Brevital anesthesia, facial sensory testing in the conscious patient, electrical stimulation for needle localization and thermaster control of the radiofrequency lesion probe. The method has the expected low mortality and morbidity attendant a radiologically controlled percutaneous procedure, and allows reliable production of temperature graded durable analgesia with minimal risk.

Intravenous Brevital permits work with an anesthetized, but promptly arousable patient. Thermaster control of the temperature and lesion size allows more accurate lesion making. The locations of the paresthesias provoked by low voltage stimulation give an accurate guide to the position of the electrode in the root or the ganglion. Since the shaft of the device moves diagonally medially, as well as posteriorly, one need only insert it more deeply to enter 2nd division fibers. Corneal anesthesia can be avoided, but hypalgesia of the 1st division can be deliberately produced to control pain in the face.

In some institutions, radiofrequency lesions of the retrogasserian root using light Innovar anesthesia and physiologic stimulation for localizations

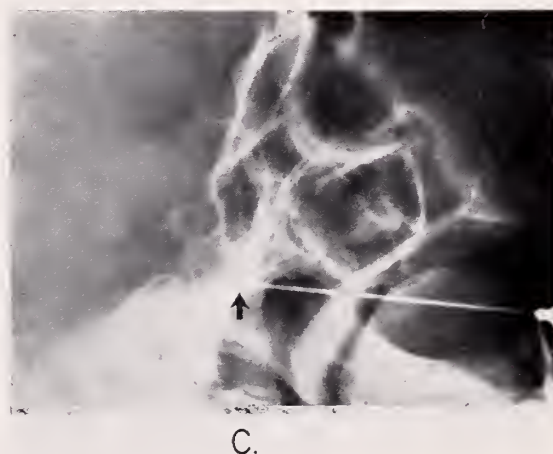


Fig. 2C. Later x-ray showing needle passing through foramen ovale (arrow) with tip in gasserian ganglion.

have supplanted the subtemporal surgical procedure, and it is now an acceptable mode of therapy at the Mayo Clinic and Massachusetts General Hospital. It permits the controlled production of any degree of sensory deficit in any division of the nerve.

The procedure was introduced in this country

at the Massachusetts General Hospital. There, Sweet concluded after 32 successful coagulations in 30 patients: "We are impressed with the advantages of this method for most patients with idiopathic neuralgia."<sup>3</sup> Sweet's unique contribution was the development of an electrode with an attached thermaster for producing controlled radiofrequency lesions.<sup>3</sup> In 26 cases of stereotaxic gasserian ganglion operations performed at Mayo Clinic, only one patient failed to obtain relief of his pain, and there were no complications from the procedure.<sup>1</sup> Half of the patients in that series had previous surgery without relief of their pain.

### Summary

When medical therapy fails, radiofrequency stereotaxic lesions offer an acceptable alternative to other surgical procedures for trigeminal neuralgia. Radiofrequency stereotaxic gasserian ganglion and sensory root lesions overcome the need for prolonged general anesthesia and major surgery. The likelihood of recurrence of pain is reduced because the lesion is in the ganglion and posterior

root rather than in the peripheral branches. The procedure utilizes brief periods of Brevital anesthesia, electrical stimulation for needle localization, and thermaster control of the radiofrequency lesion probe. In a series of 18 patients the method had the expected low morbidity and mortality attendant of a radiologically controlled percutaneous procedure. All patients obtained relief of their pain and no patient has had a recurrence of pain since the first procedure was done two years ago. The only undesirable feature was extension of the numbness beyond the confines of the involved division in three patients.

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### THE DAY'S DEMAND

God give us men! A time like this demands  
 Strong minds, great hearts, true faith and ready hands;  
 Men whom the lust of office does not kill;  
     Men whom the spoils of office cannot buy;  
 Men who possess opinions and a will;  
     Men who have honor—men who will not lie;  
 Men who can stand before a demagogue  
     And damn his treacherous flatteries without winking;  
 Tall men, sun-crowned, who live above the fog  
     In public duty and in private thinking;  
 For while the rabble, with their thumb-worn creeds,  
 Their large professions and their little deeds,  
 Mingle in selfish strife, lo! Freedom weeps,  
 Wrong rules the land, and waiting Justice sleeps.

—Josiab Gilbert Holland



# Psychiatric Aspects of the Marijuana Problem

RONALD A. SHELLLOW, M.D.

**Abstract:** Psychologically it is impossible to differentiate between users and nonusers of marijuana. People who choose marijuana are more active in behavior than those who choose other drugs. A small percentage of users suffer from severe characterologic defects and require psychotherapy to alter the character. The behavior of most users is best modified by therapies based on learning theory.

I should like to discuss the psychiatric aspects of marijuana from the standpoint of the characteristics of the broad sample of users, then to briefly review the extremely limited literature on research into the choice of marijuana as a drug and then, thirdly, discuss the characteristics of those people who get into difficulty from using cannabis. Good papers on characteristics of populations of student users come from Brill<sup>1,2</sup> at U.C.L.A. and Goode<sup>3</sup> at N.Y.U. These papers cover only short-term evaluations; there is no literature to date on long-term psychological studies. The essential results of both of these studies were that it was impossible to differentiate psychologically between the populations of marijuana users and nonusers. It may be surprising to realize that adolescents who use marijuana are not different from adolescents who don't use marijuana. Let me discuss a few of the details.

## Psychiatric Characteristics

Of this sample,<sup>1</sup> 48% of the undergraduate population had never tried marijuana but of these 78% planned to try it. Of the users, 5% had only tried it; 13% had used it but had quit; 26% used it three times or less per week, and 8.5% were heavy users, defined as more than three times a week for two years or more. Median age of "turning on" for heavy users was 16½ years as compared to 18 years for all users. Adolescents were introduced to marijuana use in 80% of cases

by close friends or siblings who were themselves users. Very few of the users in these samples were given cannabis first by individuals considered true pushers. Marijuana use did not seem to cause the use of other drugs, but it did seem to accompany use or experimentation with other drugs. Amazingly, to me, there were "no statistically significant differences in the academic performance in either high school or college of users and nonusers of marijuana, even among the daily smokers . . . no differences in numbers of probations, suspensions, disciplinary actions or expulsions. We did find that a higher percent of chronic users than nonusers intended to go on to graduate school in a doctoral program. (18% vs. 11%)."<sup>1</sup>

The age of peak usage was 19 to 20 with a drop-off after age 22. Ethnically, 38% of Whites and Spanish-Americans used marijuana; 21% Blacks and 10% Orientals used it. When suburban vs. rural or urban background was compared, twice as many suburban as compared to others were users. Jews were slightly over represented in the user sample as compared to their representation in general. Only 6% of users regularly attended any religious services.

Use of drugs, alcohol or tobacco by parents or siblings was positively correlated with use of marijuana. There was no correlation between use and parent's marital status, education, occupation or socioeconomic class. If parents were liberal politically, twice as many of their children would smoke than if they were conservative. No difference appeared between users and nonusers in terms of homosexuality or illegitimacy. Users began sexual intercourse at a younger age. Interestingly, women nonusers complained of dysmenorrhea three times as frequently as users.

No difference was found between groups in terms of legal difficulties, although users had more traffic offenses. This might be expected because 42% of heavy users reported that they drove automobiles when "stoned." Users also tended to be more politically liberal and politically active.

You can see that the student likely to use marijuana cannot be distinguished from his "straight" colleague. A user would likely be white, from a

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Presented before the Section on Medical Aspects of Marijuana, 99th Annual Meeting, Florida Medical Association, May 11, 1973, Bal Harbour.

suburban background, with parents who used drugs, alcohol and cigarettes, and were politically liberal. After he became a chronic smoker he would do as well in school as his "straight" friends, would tend to be politically left and active and would not go to church, would have fewer symptoms of sexual dysfunction and not have any more trouble than anyone else with school or legal authorities. These differences are not great enough to define users as a separate class, psychologically.

The use of marijuana in most cases, then, is a behavior rather than a symptom of emotional disorder or of the breakdown of society or other calamities. It follows, then, that if someone wishes to modify this behavior, the most effective techniques would be those based on learning and conditioning theories. I shall return to this later.

### Choice of Marijuana

There is a yet unknown, small percentage of users who go beyond the stage of chronic use into a state of being "stoned" all the time, and who are also candidates for getting involved with drugs even more dangerous than marijuana. Why do they select marijuana rather than opium, cocaine, barbiturates, amphetamines, alcohol or something else if they want to take drugs? Obvious factors are availability, acceptability and economy, but I would like to focus on the psychological factors for the purpose of this paper.

When users are asked why they take it, they characteristically reply: for euphoria, mellowness, to decrease tension, slow down time, intensify tastes and sounds, increase sexual pleasure, for sleep sedation, and to increase awareness in communications with others. Most respondents replied that they took "grass" for social entertainment or before venturing out to a public event in order to feel good, to relax, or as something to do with friends. Brill summarizes that the marijuana user is "a little depressed, likes to take risks, and seeks stimulation rather than avoiding it."<sup>2</sup> Psychoanalytic authors<sup>4</sup> after first saying that one cannot separate, psychologically, users from nonusers speak of the depression inherent in users, the passivity of their personalities, and of a conflicting drive toward stimulation and activity as opposed to the resignation to passivity of the users of other drugs. Also involved in the selection of marijuana as an intoxicating drug are factors well known to all of us: curiosity, peer acceptance, rebellion, defiance, escape, relief and symbolically, in the intoxicated state, a fantasy of detachment and independence. The last is of particular importance

in understanding why adolescents are so susceptible to drug use. All adolescents must incorporate new ego mechanisms to cope with the increased energy and drive strength ushered in by puberty.<sup>5</sup> They must also find devices to effect a separation from the primary familial love objects and transfer to the outside world. Effects and symbolism of marijuana can supply the illusion that a young person is coping with drives and effecting emancipation from parents while, in reality, it is suspending the coping mechanisms and doing nothing to free him from dependency. Fortunately, most people seem to be able to smoke and go on with their usual lives, but a small percentage drift into a state of chronic intoxication or move on to "harder" drugs.

### Those in Difficulty

In these people it is not the drug but the impulse that causes the difficulty. According to Rado's 1933 paper,<sup>6</sup> the person likely to move in this direction gives a history of severe depression, great intolerance to pain, persistence of infantile feelings of self-centeredness and omnipotence. Marijuana is smoked, and there is a transient loss of interest in current reality, a turning to wish-fulfilling fantasy. It is as if one can be self-centered and imagine he is omnipotent. A user says, "For the first time in my life I felt normal."<sup>4</sup> Moreau in an 1845 paper on cannabis<sup>5</sup> pointed out that there is an instantaneous analgesia and loss of depression which are transient and followed by an increase in both pain and depression. So the user who began with depression and pain had a temporary relief and now finds himself back in it. A cycle has been created; a "pharmaco-thymic regime in which he turns away from . . . activity . . . disregards . . . his affectionate relationships. Pharmacogenic pleasure . . . is autoerotic and modeled on infantile masturbation".<sup>6</sup> To restate it: the personality of the "continuously stoned" person is a basic depressive character with intolerance for pain and frustration. He learns to use marijuana to maintain self-regard and satisfaction. These effects are transient, followed by increased depression and pain, and only prevent or delay learning to tolerate frustration or maintain real object relations.<sup>5-8</sup>

For the person in this position, treatment must be directed to the characterologic problems. This would mean intensive psychotherapy or psychoanalysis. Unfortunately, the same problems—depression, pain, frustration, confrontation with the realistic amount of power one possesses—come up



in the treatment situation. These frequently cause the patient to leave treatment and return to drugs. The success rate in different series is between 20% and 30%, but it still is the only effective treatment.

In the majority of marijuana users, if one wishes to control the behavior, one should use behavioral, conditioning therapies with systems of rewards and punishment as the effective means of modifying the behavior. The success of certain teenage programs speaks to the effectiveness of these approaches. Using environmental disruptions and peer approval and disapproval as stimuli, they are able to produce a rather high number of kids who stop smoking.

### Summary

It is impossible to differentiate psychologically between the normal population and the bulk of the population of marijuana users. Both groups seem to perform equally well. Marijuana users appear to be motivated by greater drives toward activity and less toward resignation and passivity than

users of other drugs. Modification of this behavior is best accomplished by use of reward-punishment systems. A few "pot-heads" are driven by long-standing character difficulties involving chronic depression, low frustration tolerance and feelings of omnipotence. The prognosis in these cases is poor, but the only possible treatment is psychotherapy.

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**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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## Special Articles

# An Experience With Nationalized Medicine or Where Can I Find a Doctor?

DANIEL B. NUNN, M.D.

Last Summer, while attending a medical meeting in Toronto, Canada, I sustained a freak eye injury which prompted me to seek medical attention. This marked my first experience with a system of nationalized medicine. The difficulties I encountered in obtaining medical care were a revelation to me, and would seem worthy of documentation especially for those persons who view nationalized medicine as a panacea for all maladies.

The accident occurred around 11:00 p.m. when my son inadvertently poked his finger into my right eye while reaching for a pillow in the dark. Because of the resulting pain and tearing in my eye, I telephoned the hotel physician with the help of the switchboard operator. The physician was polite and sympathetic, but informed me that he was unable to handle this type of injury; therefore, he advised that I visit the Emergency Room of Toronto General Hospital (a celebrated institution) where the services of an ophthalmologist were available. Taking this advice, I arrived at the Emergency Room near midnight, and was greeted by a civil lady who asked only a few questions to complete a patient information form. Noticeably, there was a lack of interest in my insurance, and being somewhat naive, I attributed this to professional courtesy. After sitting in a reasonably comfortable waiting room for about 15

minutes, I was ushered into a small room containing six vacant hardback chairs. During the next two hours, I was approached by no one except a local inebriate, with a minor forearm laceration, who was interested in obtaining a light for his cigarette. Curiously, I noted that only one seriously injured patient, who turned out to be dead on arrival, entered the Emergency Room throughout my two-hour wait. With the clock chiming two (a.m.) and the realization that my meeting would reconvene at 8:00 a.m., I walked back to the admissions desk and inquired if there was any other hospital where I might receive attention for my eye. The clerk willingly offered the name of "the only other hospital with an eye service in Toronto" (a city with a population of approximately 2½ million persons). After explaining my predicament by telephone to a nurse at the other hospital, I was informed that I could not be seen for several hours because of the large number of patients already waiting. Feeling thoroughly frustrated and exasperated, I concluded that my best course of action at this point would be to get some sleep and try again to see an ophthalmologist later in the day. Before leaving the Emergency Room, however, I accosted a passing nurse and requested some eye ointment. The nurse, seemingly embarrassed after learning the details of my story, signaled an intern who immediately proceeded to in-



spect my eye with a flashlight. When I asked about the services of an ophthalmologist, I was told that it would take an additional 30 minutes to awake the physician on call and besides he always refused to see patients at that time of the morning. Grievously disappointed that I had not been given this information earlier, I welcomed the cursory examination and the instillation of "the standard eye ointment provided by the government" into my injured eye. An effort to apply an eye patch, however, was unsuccessful because, as I was told, the correct type of tape was not available. I was subsequently discharged from the Emergency Room at 2:45 a.m. with a slip stating that the services of an eye clinic were available beginning at 9:00 a.m.

Around 9:00 a.m., the same day, I telephoned the eye clinic at Toronto General to find out if I might see an ophthalmologist during the two-hour lunch break scheduled for my medical meeting. To my chagrin, I was informed that this was impossible since the clinic closed at noon on Friday and that to be seen today would require a two-three hour wait. In desperation, I turned again to the hotel physician who now told me that he did not begin work until 1:00 p.m. since under the system of nationalized medicine he was paid regardless of the hours he worked. (I later learned that if a physician does not participate in the nationalized system of medicine that his income is limited to

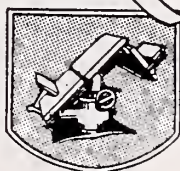
a certain figure which is supposed to reflect a compromise between the practice of good medicine and the doctor's mercenary interest). After reciting my dilemma to the hotel physician and reassuring him, at his request, that I was a bona fide medical doctor, he agreed to meet me at his office at 1:00 p.m. At the designated hour, I was met by the physician in his single-room office consisting of a desk and chair, one examining table, and a curtain across one corner of the room to provide dressing space. The physician, quite friendly at this point, made a few comments about the brotherhood of medicine then whisked me upstairs to the office of an ophthalmologist. After the usual social amenities, I was asked if I had any objection to being used as a teaching case to which I quickly replied no. I am happy to say that the customary fluorescein staining and slit lamp examination followed during which time several unidentified persons were brought in to view my corneal laceration. Fortunately, it took me only a little over 24 hours of mental anguish and frustration to learn that I would continue to see out of both eyes. Perhaps I should hope that I will be so lucky again if serious illness or injury befalls me in a system of nationalized medicine. But alas, pity the sick or injured layman without the professional courtesy I was afforded!

► Dr. Nunn, 2105 Park Street, Jacksonville 32204.

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# "We Can"

THAD MOSELEY, M.D.

In 1963 State Medical Journal Advertising Bureau finances and spirit had been at a low level for several years. That year I spoke at a meeting of the organization on "Can a State Medical Journal Compete Economically and Scientifically with the National Journal?"

My "Yes" was qualified with several "If's."  
If it creates for itself a sphere of practical usefulness.

If it utilizes all the methods at its disposal to educate the potential contributor and the potential reader.

If constant alertness governs the editorial and production policies.

Three spheres of influence were listed in which the state medical journal should have an unchallenged opportunity:

Dissimination of official information for and about the state association.

Registering the thoughts of the members as editorials and their experiences, good and bad, as scientific information.

Educating the society's membership through publication of selected articles and papers.

In summary I stated: "The state medical journals will survive as long as we can demonstrate to our advertisers that they are being read; that the journals *are being read* because we give our readers something they need and something they get in no other journal."

Today our problems are much the same, though the causes have varied.

Plaguing the pharmaceutical manufacturers and causing concern for the future are government approval for new products, truth in advertising, monopoly implications, empirical prescribing, costs of experimentation to develop new products, over-the-counter medicines, and premixed medications.

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presenting a broad range of information, often in colorful and attractive spreads.

Among us in ever-increasing numbers are a more specialized group of physicians who usually are oriented toward a specialty journal presentation of material in their particular field.

At a time when the state medical society is trying desperately to keep costs at a minimum, the cost of producing the journal has increased significantly which makes a production deficit even more embarrassing.

Nationally conducted readership surveys frequently serve as a basis for advertising budget allocations; our journals have conducted few statistically valid surveys within recent years.

These problems and others—some new and more old—plague us.

Recognition of an illness and its diagnosis are basic. We must know the diagnosis to effect a cure. My diagnosis is reactive depression, chronic and subacute. This group must think objectively and act positively. We must shelve the natural tendency to react to the present situation.

Now what can we do?

Have you recently urged your readers to treat the drug detail man as a member of the continuing education team? Do you mention the ads placed by his company in your journal and say, "Thank you"?

Have you stopped at pharmaceutical booths when attending medical meetings?

As potential advertisers, have you looked within your state for products outside the pharmaceutical field which might be of interest to physicians?

Has your medical society considered the legal problems relating to the drug field which are our problems as well as the pharmaceutical manufacturers? Have you communicated with your congressman concerning these problems stating your opinion and the opinion of your House of Delegates? As an editor, have you advised your readers what is being done in Washington and the implications of these actions?

Editor's Note: This paper was presented before the State Medical Journal Advertising Bureau Biennial Journal Conference, September 22, 1973, at Atlanta, Ga. Intended for the benefit of editors and managing editors, it has a message for everyone in organized medicine, and for this reason, it is herein being published with Dr. Moseley's permission.



Because we are involved in the problems of the pharmaceutical industry, we must become more aware of the facts and form opinions which we support. The manufacturers do not want a controlled opinion, but they are justified in asking for a knowledgeable physician group capable of discussing and advising and willing to express their opinions. They believe, and we must recognize, that under the guise of safety it is easy to infringe on personal liberties.

Have you discussed cost factors with your publisher, studied methods of cost control, and investigated the possibilities of the cooperative buying of paper?

Have you involved your society's governing board in your affairs, sought the guidance of its members, and followed their wise suggestions?

Are you keeping alert to the problems and looking for solutions at home?

The State Medical Journal Advertising Bureau has always been a mechanism for advertising solicitation at the national level. It does a good job but with our help can do a better one.

We must offer a competitive product.

I believe the time has come to consider a joint effort to obtain pertinent editorial material which has the color and appeal found in some of the controlled circulation magazines. It could be in the form of a tip-in paid for by the advertisements interspersed among the reading matter. It would not replace the present format of the journal but would supplement it—if you choose to use it.

This could increase your reader interest, book appeal and journal size. A committee from your membership should investigate the possibility of obtaining the preprinted section. For financial reasons it must be done as a cooperative effort. Scientific information of this calibre could certainly be utilized in the continuing medical education program in the state and would reinforce the Journal's importance in this effort. You have the organization and the need. This may offer some means of combating the competition of the throw-away journals.

Readership surveys will take care of themselves if we have a product that interests the physician. Color, format and contents govern the degree of this interest. Our job, then, is to obtain the best of each at a reasonable cost. Cooperative efforts may accomplish this goal, while permitting each journal to maintain its personality.

From FUTURE SHOCK comes a statement I find apropos: "Instead of rising in revolt against future change/shock, men must anticipate and design the future. This is the ultimate goal of social futurism—the subjugation of the process of evolution itself to conscious human guidance."

SMJAB can meet our needs, but it must have the cooperation of each state medical journal. It is essential that we work positively to solve our problems.

► Dr. Moseley, 2005 Riverside Avenue, Jacksonville 32204.

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**DOCTOR, MARK THESE DATES ON YOUR CALENDAR:**

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**FLORIDA MEDICAL ASSOCIATION**

**DIPLOMAT HOTEL – Hollywood**

# Disability Insurance Under Social Security

A. E. OGDEN, M.D.

**Abstract:** This article gives the practicing physician in Florida information that might be of interest to him relative to the Social Security disability program and the role of the Florida state agency in this federal program.

In addition to the general background material, the following points of particular interest are discussed:

1. Although the determinations are made by the Florida state agency, the requirements for the disability are established by the Social Security Administration.
2. The role of the team of physicians working in the state agency in making the

determination is discussed.

3. The article brings out the fact that over half of all applicants applying for benefits are not disabled and are therefore denied; therefore, the article points out the importance of information submitted by physicians even on those patients that the physician knows are not disabled as well as information on patients he knows are disabled.
4. Responsibility of the patient in obtaining medical information of record and in paying for preparation of reports on information of record is explained.

Whenever a physician is requested to furnish a medical report in connection with a patient's claim for Social Security disability benefits, it's a reminder that Social Security is not just for the retired. It also provides benefits for those who cannot work because of serious illness or injury. Currently 3 million men, women and children are receiving benefits. In Florida this coming year, approximately 50,000 individuals will apply for benefits. About half of them will be turned down and the other half found to meet the requirements for disability.

A person under 65 years of age may be eligible if he has a physical or mental impairment severe enough to prevent him from doing any substantial gainful work for a year or longer. Amounts based upon earnings range from \$84.50 to \$345.50 a month for the worker or a maximum of \$620.40 monthly if he has a family.

## Who Can Get Benefits?

A disabled worker under 65 and his family if he has worked under Social Security for a certain length of time, ordinarily five of the ten years preceding onset of disability. Special provisions apply to workers disabled by blindness allowing them to qualify with even less work under the program. For the worker who becomes disabled before he reaches 31, the work requirement ranges with age to as little as 1½ years.

A person continuously disabled since childhood (before age 22) if one of his parents (in some cases a grandparent) who is covered under Social Security retires, becomes disabled or dies. The mother of the disabled son or daughter may also receive monthly benefits as long as she has the child in her care.

A disabled widow 50 or over if her late husband was covered under Social Security, and if she meets the specified level of medical severity. This also applies to disabled dependent widowers and certain disabled surviving divorced wives.

Dr. Ogden is chief medical consultant, Bureau of Disability Determinations, Division of Vocational Rehabilitation, Tallahassee.



## Reporting Medical Evidence

When the patient applies for benefits, he is required to submit medical evidence. He is responsible for payment to the physician for preparation of this report whether he obtains it himself or the state agency requests it in his behalf. This evidence usually consists of data from the records of his treating physician, clinic or other medical source. Our experience with the disability program in Florida indicates that in about four out of five cases no further medical development is needed because of the fact that the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work.

This information may be requested on the patient's behalf by a Social Security office or more often by the Bureau of Disability Determinations, Division of Vocational Rehabilitation, Department of Health and Rehabilitative Services. The Bureau has both physicians and trained disability examiners on its professional staff. They form a balanced team which can handle a strictly medical issue and a complete assessment of vocational factors which bear on the disability decision. At present 14 full-time and 11 part-time physicians are in the Bureau and in the next few months we will add an additional three full-time physicians. The majority are board certified in their specialty.

With the assistance of staff or reviewing physicians, we endeavor to make requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal is to ease the reporting burden of the physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of all relevant information.

The evaluating physician in the Bureau does not see the patient. He depends upon the information supplied by the physician or clinic to assess the severity of the impairment, its expected duration and the extent of residual functional capacity. The disability decision rests largely on the quality of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, usually will be sufficient for us to evaluate the claim and make a decision.

For example, if the patient experienced a myocardial infarction, we would look for such information as date of occurrence, place and duration of hospitalization as well as results of x-rays, electrocardiograms, and other laboratory studies. Serial EKG tracings should, whenever possible, accompany the report. Equally important is the medical history, including onset of chest discomfort, relationship to effort, intensity, location, radiation, regularity and to what extent relief is obtained by rest or medication.

If a report does not contain all the findings necessary to make a proper decision, a reviewing physician may recontact the medical source. However, the additional time required may delay the patient's claim and can add up to a significant additional program expense.

Establishing the onset date of disability, often a key factor in determining the beginning date and amount of the claimant's benefits, is frequently difficult. Therefore, it is extremely helpful if the reporting physician includes the date of each important fact or finding. To save time, he may enclose photocopies of pertinent sections of the patient's chart or of hospital or consultant's reports.

## Criteria for Evaluating Disability

In making disability determinations, our agency uses medical criteria developed by the Social Security Administration. This insures uniform evaluation of all applicants and helps simplify and speed the decision process. These criteria were worked out with the aid of practicing physicians, major medical organizations and SSA's Medical Advisory Committee.

The complete criteria including the medical findings listed by body system are contained in a handbook designed especially for professionals who come in contact with the disabled population. The handbook describes impairments in terms of specific symptoms, signs and laboratory findings that are presumed to be severe enough to prevent a person from working for a year or longer. A copy may be obtained from the Bureau's Medical Section, 1309 Winewood Boulevard, Tallahassee 32301.

► Dr. Ogden, Bureau of Disability Determinations, 1309 Winewood Boulevard, Tallahassee 32301.

# The Ways We Review Ourselves

VERNON B. ASTLER, M.D.

I have been given a general briefing by the Acting Chairman Representative Randy Avon, concerning the general scope of material to be covered by this Committee.

The first item of inquiry concerned is altering the medical practice act so as to require mandatory membership in the Florida Medical Association in order to maintain licensure. It is our position that there is already an adequate system for controlling the examination and licensure of physicians in the State of Florida. While it is true that there is a tiny fraction of physicians who are practicing poor medicine, newer proposals recently developed by the Florida Medical Association have offered ways and means to control this small minority of all doctors.

Physicians have long been leaders in the areas of self-policing. The American College of Surgeons was the original body initiating formation of the Joint Commission on Accreditation for Hospitals; then joined by the American Medical Association, the American College of Physicians and the American Hospital Association to set high hospital standards. At the present time physicians have served voluntarily and without pay on Chart Review Committees, Tissue Review Committees, Peer Review Committees, Nursing Home Review Committees and various other bodies in an effort to keep standards high and medical delivery good.

Physicians are presently under a well disciplined system of self examination and evaluation by their colleagues. Most physicians engaged in active practice belong to one or more hospital staffs; as such, each is first subject to scrutiny by the Credentials Committee. Then, if approved, he is given a probationary status for a period usually lasting one year and a sponsor is appointed who is a well-qualified existing physician of proven merit who serves to observe the work and record of the new physician. This doctor in the hospital setting then comes under the review of Tissue Committees which examine all tissue removed in the oper-

ating room. Chart Committees routinely review the hospital records for completeness and content as well as the quality and type of work offered to each patient. The department to which this doctor must belong (usually the department in his specialty such as surgery, medicine, etc.) has meetings usually at a monthly period to review the work in their particular department. Customarily all deaths are reviewed in addition to all charts of patients with an unusual diagnosis or unusual illness, or those in which an unexpected outcome has occurred.

Secondly, physicians most commonly join their County Medical Society and as such become a member of the Florida Medical Association. Here their caliber of practice is again investigated by the Credentials Committee prior to their acceptance and their form and manner of professional practice is evaluated. Again they are placed on a probationary status and the nature of their behavior and professional practice is observed and evaluated. At this level the public as well as other doctors have access to the County Medical Grievance Committee which will hear and investigate any complaints concerning a doctor regarding type of treatment, charges, unnecessary hospitalization, etc. There is also customarily an Ethics Committee which would hear complaints concerning unusual or unethical behavior of any physician. These Committees make recommendations to the full society which has the power to exonerate the physician, reprimand, offer probation or expel the physician from the county medical society and in this way from the state medical association.

All physicians must also come under the Florida Medical Practice Act and under the Florida State Board of Medical Examiners. This is a ten member body composed of practicing physicians appointed by the Governor who serve for a four year period. These physicians serve only for a stipend and their motives are basically altruistic and their judgment is proven sound in nearly all cases. This body has the power to serve as a quasi-judicial body and if necessary to go so far as to revoke medical licensure.

Presented by Dr. Astler, President of the Florida State Board of Medical Examiners, in testimony before the Insurance Committee of the Florida House of Representatives, September 1973.



In the past two years the Florida Medical Association has developed a Committee on Membership and Discipline with regional representatives in all areas of the State who stand ready and willing to investigate their fellow physicians if called upon to do so.

With the coming Professional Standards Review Organizations, data on all physicians will be banked in giant computers and available to Review Committees, indicating not only the charges but the types and frequency of various procedures. This information should offer a ready gage for judging the quality of medical care delivered by individual participating physicians. This will necessarily involve all physicians who participate in any form of Social Security medical payments.

Since the suggestion arose that medical membership in the Florida Medical Association be mandatory for licensure (similar to the Florida Bar Association) I have reviewed the numbers of actions taken against lawyers by the Florida Bar and have learned that approximately 200 disciplinary actions were taken since 1955. Similarly in the past seven or eight years the Florida Board of Medical Examiners have taken 94 disciplinary actions regarding physicians and have invoked the Sick Doctor Statute in 18 instances. None of the 18 cases under the Sick Doctors Statute have appealed the disposition of their case. This would certainly allay the fears of those members of the legislature who felt that this might be a misused tool once given to the Florida Board of Medical Examiners. However, the percentage of doctors involved in poor practice or other infringements of the Medical Practice Act is small. As indicated, 94 actions were taken and as you know there are presently 10,290 licensed M.D.'s in the State of Florida and a total number of 17,071 M.D.'s who have paid their fees as of February 1973.

Numbers of physicians licensed have consistently exceeded the population growth of the State of Florida. In 1971, 2,095 licenses were issued (134 by endorsement). In 1972, 1,629 licenses were issued (490 by endorsement) and in 1973, 1,410 licenses were issued (441 by endorsement). I might mention that we now recognize the FLEX Examination and the National Board Examinations. FLEX is currently used by 47 states in addition to Washington, D. C., Puerto Rico and the Province of Saskatchewan in Canada. Ninety per cent of all medical schools use National

Boards proving that we have a wide base of endorsement allowing many physicians to come to Florida. For the past four years we have ranked only behind the State of New York and California in the number of licenses issued.

The Florida Medical Association and its members are dedicated to correct instances of ineptitude, indifference, or apparent avarice. Our profession is pledged to correct these deficiencies and transgressions; however, when we consider how our system of health delivery is performing at this moment we must say it is the highest standard of medical care the world has known. I would suggest, therefore, that we seek solutions to specific problems for specific populations and not destroy current working systems now serving the majority of our citizens extremely well. Government spending amounts to approximately four hundred and six billions of dollars annually or 44% of everyone's income. This amounts to an average of \$8,000 per family versus only \$380 per family spent for Medicare and Medicaid government cost. These figures are not unreasonable for the high standard of health delivery offered in this country.

The Florida Medical Association, this past year, has also invoked a mandatory number of postgraduate hours totalling 90 hours every three years or 30 hours per year, to maintain active status in the Florida Medical Association. The Association cooperates in many postgraduate courses and seminars to help doctors upgrade themselves each year.

So you can see, gentlemen, the Florida doctors are policing their own and doing a good job. We have instituted within the past two years a Committee on Membership and Discipline with regional representatives in all areas of the state. These representatives stand ready to review or to hear cases or charges brought against physicians in their geographic area and offer unbiased opinions to the parent organization. These modalities should go a long way in correcting the small minority of practicing physicians who are inadequate in the eyes of their colleagues.

Our society stands willing to communicate, attend hearings, or offer testimony any time this committee or the legislature should request it.

Thank you for the opportunity of appearing here.

► Dr. Astler, 2800 South Seacrest Boulevard, Boynton Beach.

# FLAMPAC Report

EDWARD G. HASKELL JR., M.D.

In 1972, the Florida Medical Political Action Committee was recognized as Number One PAC in the nation. The favorable impact of FLAMPAC's 1972 election efforts are clearly shown by the fact that ten members of Florida's congressional delegation are sponsors of Medcredit and that all of the six major state legislative objectives for 1973 were achieved.

This is surely a record that all PAC members can be proud of, but is only a beginning. FLAMPAC can continue its growth and effectiveness in the election process only by the active participation of all physicians.

There are many forces at work at both the state and national level that are constantly trying to erode the private practice of medicine. At the national level, we have the threat of National Health Insurance, Health Maintenance Organizations and even PSRO's, at the state level there are constant attempts by the State to provide direct delivery of health care, to allow pharmacists to substitute prescriptions, and to interfere with the private property rights of physicians concerning patients' medical records. These are only a few of the problems that will be faced in the coming years by medicine and your FLAMPAC Board of Directors seriously and enthusiastically accepts its responsibility to assist in developing a better medical legislative climate.

FLAMPAC is *YOUR* organization for effective political action; it is not an organization

dominated by the thinking of a few physicians. It is a Board composed of two of your colleagues from each congressional district with liaison representatives appointed from each county medical society. The members of the Board of Directors are approved by the Florida Medical Association Board of Governors and the quarterly meetings are open to all FLAMPAC members.

During the past year a newsletter has been started which will be mailed to all FLAMPAC members disseminating pertinent information concerning PAC activities. In addition, more specifics are available through the offices of any of the Board members or officers.

The success of FLAMPAC should not be judged on the participation of any one individual political campaign, but in its overall benefit for medicine in achieving success in the majority of campaigns in which candidates are elected who understand the needs of the practicing physicians and his patients.

FLAMPAC can not survive and grow without your individual active participation. You as an individual physician can also not be as effective in the political process as can a well-organized and properly directed organization of your colleagues.

FLAMPAC's membership is continuing to grow and I am confident that we can look forward for 1974 to be another successful year. For those of you who have joined, we thank you; for those of you who have not, please take time now to join FLAMPAC. Our year will not be a success unless we can count you as one of its members.

---

Dr. Haskell is president, Florida Medical Political Action Committee.

## Hippocrates Said

Where there is love of man, there is also love of the art. . . . Further, some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician.

*Changing Patterns, December 1971*



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## *Approvals*

\*licensed as specialty hospitals by the state of Florida Department of Health and Rehabilitative Services

\*approved by Medicare, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

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\*granted membership in the American Hospital Association, Federation of American Hospitals, Florida Hospital Association, and the National Association of Private Psychiatric Hospitals

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Tampa, Florida 33603  
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1650 South Osprey Avenue  
Sarasota, Florida 33579  
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3. FREQUENCY OF ISSUE <b>Monthly</b>		
4. LOCATION OF KNOWN OFFICE OF PUBLICATION <small>(Street, city, county, state, ZIP code) (Not printers)</small> <b>735 Riverside Avenue, Duval County, Jacksonville, Florida 32203 (470)</b>		
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MANAGER EDITOR <small>(Name and address)</small> <b>Louise Rader, 735 Riverside Avenue, Jacksonville, Florida 32203</b>		
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(Upper left) "Grandfather's Violin," by Mrs. Raymond J. Fitzpatrick, Gainesville; (Top right) "Autumn Leaves," by Carlos O. Rojas, M.D., Miami; (Left) "Spanish Doorway," by Mrs. Robert L. Stanton, Miami; (right) "Still Life With Shallots," by Floyd K. Hurt, M.D., Jacksonville, and "The Early Spring," by Mrs. Robert P. (Bonnie) Vomacka, Belleair Bluffs. Mrs. Vomacka also won the Editor's Award for her painting entitled "The Traveled Path," which appeared on the cover of the July issue of the FMA Journal.





## Editorials

### The Hope Of The World

*"And so it was that while they were there, the days were accomplished that she should be delivered. And she brought forth her first born son and wrapped him in swaddling clothes and laid him in a manger because there was no room for them in the Inn."*

Who was this child whose birth, foretold by the prophets of old, heralded by a star in the East brought wise men from afar to worship him while shepherds in the fields nearby heard a heavenly chorus singing, "Glory to God and peace among men?" Only two of the new Testament gospels concern themselves with the birth of Jesus and only the gospel of St. Luke treats it as an occasion that engendered public joy like that which we will celebrate this month. Why then does the celebration of his birth, the exact date being unknown, assume such an important place in our hearts and lives? Why has it become the most festive occasion of the year? Can it be that the image of the newborn babe touches our deepest emotions forcing us to consider the possibility of a better life? Nothing appears more helpless than the fragile form of a newborn child, yet nothing is more promising. The miracle of birth reveals the power within each mortal to make life more meaningful and more beautiful for the world while making forebears immortal in giving to their progeny the chance to mold a new generation of mankind better than the present.

Who was this child found in the temple at age 12, sitting among the doctors and asking them questions, who prescribed being "born again as a little child" to man's quest for eternal life, and who said, "Therefore, all things whatsoever ye

would that men should do to you, do ye even so to them." Who also said, "Thou shalt . . . love thy neighbor as thyself," and in reply to the question, "Who is my neighbor?" told the parable of the Jew who fell among thieves only to be befriended by the Good Samaritan. At a time when the poor, the weak, and alien strangers were considered mere pawns of the powerful, life was cheap and infanticide common; his birth was the turning point of the religious history of the world, lifting its ethics and morals and ideals, showing concern for all persons, transforming human values, giving a new dignity to man, a holy value to life itself.

Christmas then is not just an isolated occurrence but the entry into human history of a life that both animates the entire process and presages its ultimate future. Christmas repudiates the notion of a fundamental division between the spiritual and the material. Christmas brings out the nobler side of people as Jesus did when He identified himself with the lowest of them, "As ye did it unto the least of these, my brothers, ye did it also unto me." His birth was to bring humanity to mankind, but why did He not appear sooner and why has not man followed his way of life? The scriptures indicate that mankind had to be prepared for him before they could accept the fact that He had always existed and each

year the celebration of Christmas gives his followers an opportunity to retell and relive his life. As the years roll by hopefully the world grows less cruel, for with enlightenment comes understanding, and with understanding comes the ability to live together.

Over the world at this time of year the signs of failure in human relations are precipitating renewed outbreaks of war disrupted by temporary cease-fires. This could involve all nations and causes the cynic to cry, "Give Christmas back to the pagans," explaining that the Christmas season has been so perverted to become a threat to the mental and emotional wellbeing of all, as modern commercial aspects destroy the religious basis and the human warmth and merriness that grew up around it. Recommending that this lifeless caucus be left to the vultures of materialism, another date on which to celebrate the true meaning of Christmas has been suggested. Although criticised as being vagrant, phony, commercialized and unhealthy, Christmas is more than this. It is a celebration of Christ's spirit of selflessness, of unstinting love of one's brothers, of the poor and the downtrodden. The message of Christmas is peace and the prayer of the hopeful speaks so loudly that it drowns out the cry of the huckster.

Something happens to the quality of life at this time each year, a turning away from the secular toward the spiritual, a renewed sense of joyful expectations as the hearts of strangers are opened to one another, and the warmth of old friendships renewed, makes one more giving in his relation to others from a feeling of gratitude for one's own blessings. If only we could extend this season of human benevolence, sustaining these demonstrations of good will toward others in our own neighborhood, spreading from city to nationwide to an international epidemic. If we could just realize that in our own best interest for self-preservation, we must commit ourselves to practice good will toward all men, then the indomitable human spirit might recapture a vision of life that would truly generate peace on earth for all of us.

Yet, in that touching trust of childhood which can always be deceived yet never discouraged, there lies the hope of the future of the world. To bolster this hope, we need only follow the teaching of Him, the Prince of Peace who founded all progressive thought beyond any other conceivable need in our great and troubled world.

C.M.C.

---

#### *AT DAY'S END*

If you sit down at set of sun  
And count the acts that you have done,  
And, counting, find  
One self-denying deed, one word  
That eased the heart of him who heard  
One glance most kind,  
That fell like sunshine where it went  
Then you may count that day well spent.

But if through all the livelong day,  
You've cheered no heart, by yea or nay  
If through it all  
You've nothing done that you can trace  
That brought the sunshine to one face  
No act most small  
That helped some soul and nothing cost  
Then count that day as worse than lost.

—George Eliot (1819-1880)



## The Good Old Days and House Calls

In these harried days when medical practice and physicians are the brunt of so much criticism, invidious comparisons are made to the good old days when doctors were less impersonal and took time out to make house calls. The latter were considered a great support of the patient and the easing of tensions of the family.

Well, anyone old enough to remember the glory of the old ways of medical practice will recall many of the disadvantages also. The beleaguered physician in those halcyon days on making a house call was often placed in a difficult position, since he was deprived of facilities for laboratory data and the assistance of paramedical personnel that would greatly facilitate the management—from diagnosis to treatment. Such handicaps often entailed unnecessary delay as the physician returned to make further observation on the course of the malady, or the patient was subsequently hospitalized. In true emergency cases, considerable valuable and even vital time might be lost if the physician were to see the patient at home first where life-saving procedures and facilities are unavailable. Now, this is not to say that all house calls are interdicted. Many of my colleagues continue to make house calls in special cases and follow-up visits if these are in the overall interests of the patient's recovery. But it is not in the patient's interest to carry out routine house calls as in the distant past.

To cite a personal instance will serve to dramatize the great improvement in the management of illness today.

Some time ago I suffered a general feeling of malaise, with some anorexia, occasional bouts of fever, diarrhea, and exhaustion. As so many of us do, I ignored these symptoms, trusting that they would disappear in 1-2 days, attributing them to some inconsequential virus-induced indisposition.

But when they persisted for a fortnight, I was importuned to seek medical advice. My internist told me to meet him at the hospital emergency room early next morning. In the meantime, he had called in to order what tests he considered necessary. A chest x-ray, being an admission imperative, was taken, as well as a urinalysis and stool examination. The blood profile included a culture, CBC, bilirubin level, serum glutamic oxaloacetic transaminase level and alkaline phosphatase. An ECG, temperature and blood pressure completed this phase of the examination by paramedical personnel, even before the arrival of the doctor to perform his history and physical examination. The entire examination and tests were performed in a booth in the emergency room prior to room admission. I could not help but feel that the whole undertaking was highly efficient and that I had been spared a great deal of discomfort and loss of time by having all of these procedures performed at once and in one setting. When the doctor visited me again in the afternoon, he had the results of all the tests, and a firm diagnosis of infectious hepatitis was made on the basis of slight hepatomegaly, bilirubinuria, and considerably elevated bilirubinemia, SGOT and alkaline phosphatase tests, even though only subclinical icterus was present. I remained in the hospital for only two days, and was discharged home to convalesce and on to full recovery.

Medical practice has changed, but for the better. When your patients complain why you do not make house calls, take time out to explain why, and not merely because it is less convenient or more time-consuming to see patients at home.

WADE S. RIZK, M.D.

►1471 San Marco Boulevard, Jacksonville, Florida 32207.

## Who Coughed?

Cough and cold medicines are big business. It has been estimated that nonprescription items for the relief of respiratory infection symptoms are a \$430,000,000 account. Prescriptions for such preparations constitute a \$190,000,000 market for the pharmaceutical industry. More than \$600,000,000 is nothing to sneeze at—or cough at—or expectorate at. That is more than the average surgeon makes in a lifetime despite the proclamations of Dr. John Knowles of the Rockefeller Foundation.

Reports have been circulating in the medical and lay press of the dispute going on between the FDA, the medical profession and the drug manufacturers about cough and cold remedies. Until recently, the FDA was hellbent on limiting claims or outlawing certain ingredients in these medications unless specific proof of their value was forthcoming. An agreement has been reached to wait for the conclusions of a prolonged study of over-the-counter products for the relief of cold symptoms; it is hoped that this study may cast some objective light on this subject that has become heated up by the conflict between the opposing groups.

The FDA has been designated by the Congress to oversee the safety and efficacy of all drugs and its leaders view their actions as carrying out this mandate. The pharmaceutical industry obviously has a great financial stake in this controversy. Certain segments of the medical profession feel that once again the bureaucrats are challenging the ability of the practicing physician to exercise proper clinical judgment in the choice of medication for his/her patients.

In some ways, it is startling to learn of this scientific tempest in a teapot; seemingly, the FDA should have more important matters to investigate. We hear of worthwhile medications that can be used in Great Britain and European countries that are either not available here or are in an investigative status after many years. It has been estimated that less than 10% of the new drugs discovered in the world between 1963 and

1970 have been legally available to private physicians and their patients in this country. Admittedly, not all these formulations were wonder drugs, but clinically important drugs have been denied approval or have had their introduction delayed according to most knowledgeable workers in clinical pharmacology. It is particularly interesting that 3 out of 4 drugs produced under the aegis of American pharmaceutical companies at home and abroad went exclusively for the treatment of patients outside the United States.

In his *Essay on Criticism*, Alexander Pope advised us: "Be not the first by whom the new are tried nor yet the last to lay the old aside." Applying this to the present situation, the FDA might beg our indulgence on the slow introduction of new medications while at the same time might ask us to understand their efforts to expunge the worthless products from the approved list.

The matter of cough and cold remedies is not a simple one. The individual components of most of these preparations—be they expectorants, decongestants, or antitussives have stood the test of time of safety and efficacy; it is when they are joined together in wedlock that the dispute arises. The combination of expectorants and antihistamines in particular causes a rising of the gorge at the FDA. Further we become embroiled in the placebo effect of any of these prescriptions. OTC proprietary remedies frequently differ from prescription items only in the strength of the ingredients. The forthcoming study mentioned above therefore should be of some help in clarifying the problem.

It was Oliver Wendell Holmes who suggested that with few exceptions the whole of *Materia Medica* could be flung into the depths of the ocean to the betterment of mankind but with great danger to the fishes. The lesson to be learned is twofold: (a) Doubt about the value of certain medications is not modern phenomenon, and (b) Ecological concern is nothing new.

RICHARD T. DONELAN, M.D.

► 3215 Hendricks Avenue, Jacksonville 32207.





## Are they too old to swing?

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Vitamin B-12	1.5 mcg.
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Inositol	10 mg.
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg.
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 ml
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

**ACTION AND USES—DOSAGE:** 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 30, 100, and 500 tablets.

**TESTAND-B INJECTABLE:** VIALS OF 10cc.

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**Precaution**

Prolonged or excessive  
use of Anusol·HC might  
produce systemic  
corticosteroid effects.

Symptomatic relief should  
not delay definitive  
diagnosis or treatment.

**Dosage and Administration**

Anusol·HC: One suppository  
in the morning and one at  
bedtime for 3 to 6 days  
or until the inflammation  
subsides.

Regular Anusol: one  
suppository in the morning,  
one at bedtime, and one  
immediately following each  
evacuation.





## ORGANIZATION

### Dr. Walker in Advisory Post

James W. Walker, M.D., of Jacksonville, Secretary-Treasurer of the Florida Medical Association, has been appointed to the Drug Advisory Committee of the Florida Division of Purchasing. He succeeds H. Phillip Hampton, M.D., of Tampa.

### Dr. Astler Appointed

Vernon B. Astler, M.D., of Boynton Beach, advisory member FMA Board of Governors and President of the Florida State Board of Medical Examiners, has been appointed to the Committee on Physicians of the American Hospital Association. The three-year term begins January 1, 1974.

### Headquarters Staff Promotions

Two members of the headquarters staff of the Florida Medical Association have been promoted to newly-created positions.

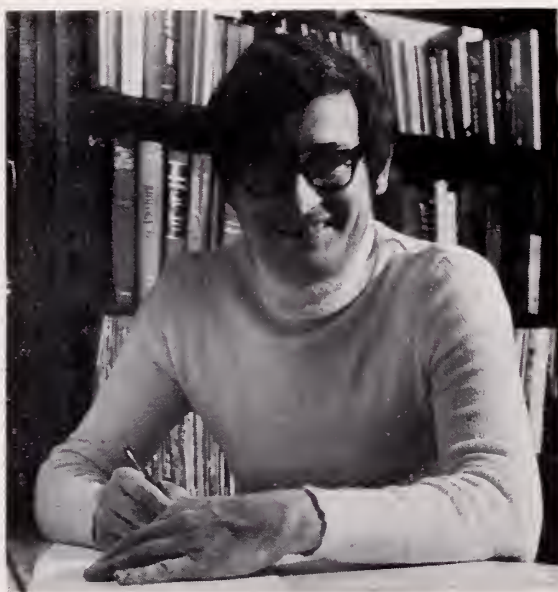
Eugene L. Nixon has been named Associate Executive Director (Programs) and Donald C. Jones has been appointed Associate Executive Director (Finance and Administration) effective November 1, according to W. Harold Parham, Executive Vice President.

Since joining FMA in 1955, Nixon has held various posts and most recently has been Director of the Scientific and Medical Services Department. Jones, an employee since 1967, has been serving as Assistant to the Executive Vice President.

Parham also announced the appointment of Philip H. Gilbert of Tallahassee as Director of the Medical Education Department. Gilbert has been with the new Florida Division of Aging.



Mr. Jones



Mr. Nixon

# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# M-M-R<sup>\*</sup>

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

### MSD suggested immunization schedule for well babies

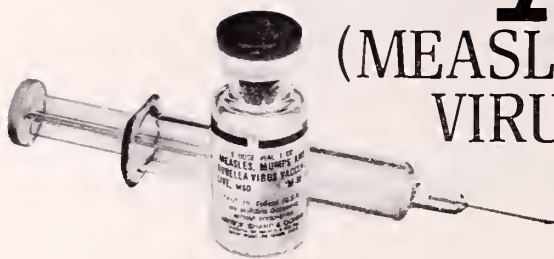
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT <sup>1</sup>
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
<b>12 MONTHS</b>	<b>M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)</b>

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

<sup>\*</sup>Trademark of Merck & Co., Inc.

**For a brief summary of prescribing information, please see following page.**



# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever; rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have

occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1-9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

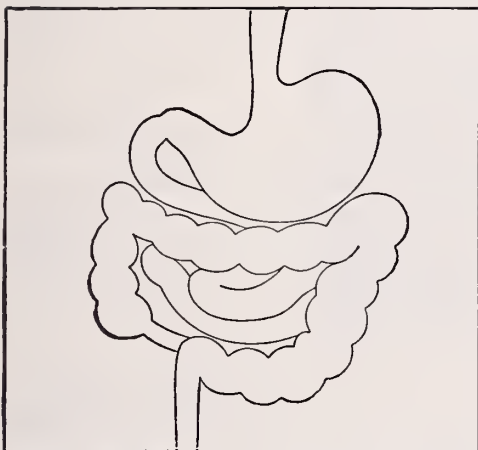
**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 3/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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The GI tract in spasm is commonly a “gas trap.”

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that “lyses” gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gas-

tritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

**Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.**

Sidonna can do more for your “gasspastic” patient. Try him on 1 or 2 tablets before meals and at bedtime.

# Sidonna®

Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

## can do more

**Contraindications:** Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.

**Side Effects:** Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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# Rondomycin® (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopical discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev 6/73



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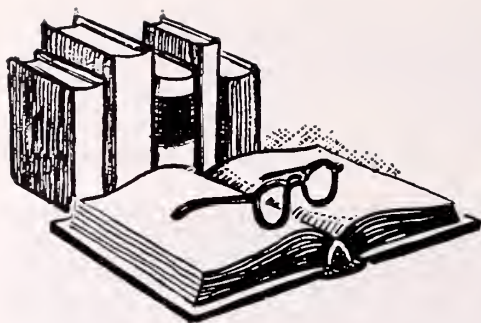
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## Book Reviews

**Darwin's Victorian Malady** by John H. Winslow. 94 pages. Price \$2.00. American Philosophical Society, Philadelphia, 1971.

John Winslow of the Department of Geography-Anthropology, California State College presents convincing evidence that Charles Darwin suffered from chronic arsenical poisoning. Darwin's medical features—keratosis, a brown complexion, trembling of the hands and chronic catarrh are consistent with arsenicalism, from having taken Fowler's solution for treatment for many years. This offers an alternative to the claim that Darwin's ill health was psychosomatic.

Winslow's book gives commentary on the medical practices of the day and mentions famous physicians and famous patients. Famous British dyspeptics include Thomas Carlyle, Robert Browning, Herbert Spencer, Thomas Huxley and George Eliot (Marian Evans).

This book is refreshingly short and inexpensive. Proof positive of Winslow's argument would be to exhume the body and test for arsenic. This remains to be done.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**Beyond the Punitive Society Operant Conditioning: Social and Political Aspects** by Harvey Wheeler, editor, Price \$8.95. 274 pages, San Francisco, W. H. Freeman and Co., 1973.

Are you confused by the significance of B. F. Skinner's theory as expounded in his book entitled *Beyond Freedom and Dignity* (Alfred A. Knopf, 1971)? Then take heart, so are some other experts! The present volume, edited by Harvey Wheeler, is a series of 19 papers by authors who attempt to assess the significance of Skinner's work.

These papers were presented at a symposium sponsored by the Center for Study of Democratic Institutions in 1972. The series of papers, including one by Skinner himself, includes psychologists, social scientists, biologists, and a historian. The two authors most likely to be recognized by physicians are Arnold Toynbee, the historian, and Alexander Comfort, British biologist with a special interest in gerontology.

Harvey Wheeler states "operant conditioning is one of the most important contributions to psychology and the social sciences in the past 50 years. Although it had always been surrounded by controversy, the storm of controversy that erupted following the publication of *Beyond Freedom and Dignity* forced a consideration of its merits, limitations, and social implications upon thinking persons throughout the world."

The opinions expressed in this book are sharply divided and keenly argued. It behooves physicians to know something of the work of a man who made the cover of Time Magazine and whose theories have stimulated so much critical comment.

F. NORMAN VICKERS, M.D.  
PENSACOLA

**The Peter Prescription: How to Be Creative, Confident and Competent**, by Laurence J. Peter, Ed.D. Pp. 24. Price \$5.95. New York, William Morrow & Company, Inc., 1972.

Rx for *The Peter Prescription*:

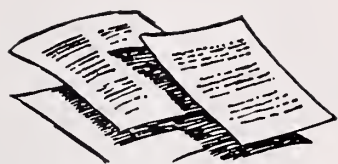
1. Read it yourself either in a single sitting, as I did, or intermittently, savoring every paragraph.
2. Encourage your spouse to read it. It has some interesting paragraphs about the hollowness of upward mobility, increasing consumption and acquisitiveness.
3. Keep it in your office or home library to lend to patients (and/or friends) as printed reinforcement for verbal recommendations you have made.

Written by the same author of *The Peter Principle*, this humorous book gives uncommon, common sense recommendations about looking at one's life objectively and ordering one's priorities. It is literally sprinkled with cartoon drawings—1880 and 1890 vintage—from *Punch*, quips and epigrams from diverse personages such as Shaw, H. L. Mencken, E. Burke and, of course, Peter.

This will be considered by various observers as a non-book, a humorous book, a philosophical-psychological treatise, or Norman Vincent Peale guidebook. There is a little something here for everyone. I predict a high volume of sales.

F. NORMAN VICKERS, M.D.  
PENSACOLA, FLORIDA





## Letters

Dear Editor:

I have compiled a listing of drugs whose names look alike or sound alike. When a pharmacist takes a prescription over the telephone or attempts to decipher a physician's handwriting, a drug product not intended by the prescriber might be dispensed. Such an error might be the result of

a sound-alike or look-alike drug.

I am enclosing a partial list of such drugs with striking similarities. Physicians are urged to exercise great care when writing or telephoning prescriptions.

BENJAMIN TEPLITSKY, R. PH.  
Brooklyn, N.Y.

Ambenyl.....	Amvicel.....	Ambodryl.....	Aventyl.....
Asminyl.....	Asmolin.....	Esimil.....	Isomel.....
Decagesic.....	Duragesic.....	Donnagesic.....	Equagesic.....
Demerol.....	Deprol.....	Dicumarol.....	Temaril.....
Digitoxin.....	Desoxyn.....	Digoxin.....	Dipaxin.....
Dolene.....	Dilone.....	Dolor.....	Dolear.....
Dyclonine.....	Dicyclomine.....	Dolene.....	Dilone.....
Esimil.....	Estomul.....	Isomel.....	Ismelin.....
Eutron.....	Ertron.....	Eutonyl.....	Entron.....
Glucola.....	Glucoron.....	Glucagon.....	Glucal.....
Hyperstat.....	Nitrostat.....	Hyper-Tet.....	Halodrin.....
Isomil.....	Isonyl.....	Isomel.....	Isordil.....
Kaomin.....	Kao-Con.....	Kaon.....	Kaolin.....
Mesantoin.....	Mestimon.....	Metatensin.....	Metandren.....
Metopon.....	Metreton.....	Metropine.....	Metrelen.....
Mylanta.....	Dilantin.....	Phelantin.....	Delalutin.....
Pantopon.....	Protopam.....	Parafon.....	Protamine.....
Persantine.....	Persistin.....	Peristim.....	Trasentine.....
Phemerol.....	Demerol.....	Deprol.....	Dicumarol.....
Tegrin.....	Tegretol.....	Tegopen.....	Tegumin.....
Temaril.....	Tofranil.....	Terfonyl.....	Tepanil.....
Tinactin.....	Duracton.....	Taractan.....	Dronactin.....
Urised.....	Urestrin.....	Uracel.....	Urasol.....
Zactirin.....	Saccharin.....	Zentron.....	Zarontin.....

## Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

**Author Responsibility.** The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

**Synopsis-Abstract.** All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

**References.** The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

**Illustrations.** Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

**Permission letters** must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

## PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings. Usage in Pregnancy:** Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

**Precautions.** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration. Children and Adults:** Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

**How Supplied.** Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.



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\*Data on file at Roerig. Please see prescribing information on facing page.

## Deaths

**Ballard, William C.**, St. Petersburg; born 1899; Medical College of South Carolina, 1926; member AMA; died May 14, 1973.

**Bennett, Grant M.**, Plantation; born 1941; S.U.N.Y., 1966; member AMA; died July 17, 1973.

**Carbonara, Francis J.**, Fort Pierce; born 1928; University of Bologna, Italy, 1952; member AMA; died August 25, 1973.

**Cirlin, Marcus B.**, Miami Beach; born 1891; University of Illinois, 1923; member AMA; died August 23, 1973.

**Cooper, Clark N.**, Naples; born 1904; University of Iowa, 1928; member AMA; died April 7, 1973.

**Dooley, Paul I.**, Largo; born 1912; University of Buffalo, 1937; member AMA; died June 8, 1973.

**Fischer, N. Robert**, Fort Lauderdale; born 1934; St. Louis University, 1960; member AMA; presumed dead August 1973 missing at sea.

**Fort, Frank L.**, Scottsdale, Arizona; born 1894; University of Georgia, 1920; member AMA; died September 4, 1973.

**Jenkins, Leslie M.**, Miami; born 1902; St. Louis University, 1924; member AMA; died March 21, 1973.

**Larsen, Charles Jr.**, Lakeland; born 1914; Duke University, 1939; member AMA; died August 12, 1973.

**Laurel, Richard J.**, Fort Myers; born 1933; University of Wisconsin, 1959; member AMA; died September 27, 1973.

**Lilly, John S.**, St. Petersburg; born 1923; Ohio State University, 1946; member AMA; died June 4, 1973.

**Logan, John B.**, Sarasota; born 1922; Jefferson Medical School, 1948; member AMA; died March 7, 1973.

**Menendez, Raymond**, Miami; born 1921; Louisiana State University, 1946; member AMA; died July 26, 1973.

**Morgen, Maximilian**, Miami; born 1897; State University of New York, 1921; member AMA; died April 27, 1973.

**O'Malley, Joseph E.**, Orlando; born 1923; University of Maryland, 1950; member AMA; died July 21, 1973.

**Reed, Howard W.**, Daytona Beach; born 1892; Rush Medical School, 1920; member AMA; died July 22, 1973.

**Roth, Edward**, Miami Beach; born 1908; Vermont University, 1932; member AMA; died June 13, 1973.

**Schifman, Seymour**, Miami Beach; born 1928; Columbia P & S, 1951; member AMA; died April 5, 1973.

**Stroud, George M.**, Indialantic; born 1915; Duke University, 1938; member AMA; died September 18, 1973.

**Thomas, Kelly C.**, Miami; born 1891; University of Arkansas, 1918; member AMA; died February 28, 1973.

**Wells, Carl H.**, Jacksonville; born 1910; George Washington University, 1941; member AMA; died August 25, 1973.

**Worley, Robert E.**, North Miami Beach; born 1941; Oklahoma University, 1966; member AMA; died August 5, 1973.



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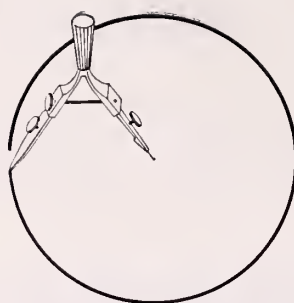
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**FAMILY PRACTITIONER** to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

**CENTRAL FLORIDA AREA:** Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

**FAMILY PRACTITIONERS WANTED:** One of the fastest growing communities in the U.S., Seminole, Florida, urgently needs family practitioners. Only minutes from Tampa, St. Petersburg, Clearwater and beach areas. Newly opened 100-bed acute general hospital. Offices provided on hospital property with rent free provisions. Will assist in referrals of patients. Write or phone Carlton K. Flores, Administrator, Lake Seminole Hospital, 9675 Seminole Boulevard, Seminole, Florida, 33542. Phone (813) 393-4646.

**UNASSOCIATED GROUP OF SPECIALISTS** desires family practitioner or other specialist to fill modern medical building in prime area of western Fort Lauderdale. 1,000-3,000 feet available about January, 1974. Excellent opportunity in fastest growing area of Florida. Write: G. A. Burkhardt, M.D., 4100 South Hospital Drive, Plantation, Florida 33313.

### Specialists

**INTERNIST, UROLOGIST, GP's.:** Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

**INTERNIST,** board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

**PATHOLOGIST, AP-CP,** Florida license. Only candidates with outstanding qualifications and references need apply. Excellent group opportunity, lovely medium size Florida east coast community. Write C-607, P.O. Box 2411, Jacksonville, Florida 32203.

**PHYSICIANS WANTED:** General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 East 25th Street, Hialeah, Florida 33013. Phone (305) 696-0842.

**UROLOGIST WANTED:** Association leading to partnership in expanding Florida community, equally distant from both coasts. Florida license and board certification required. Write C-614, P. O. Box 2411, Jacksonville, Florida 32203.

**UROLOGIST** needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to \$40,000 to \$60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-621, P. O. Box 2411, Jacksonville, Florida 32203.

**GENERAL SURGEON** needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to \$40,000 to \$60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-622, P. O. Box 2411, Jacksonville, Florida 32203.

**WANTED:** Internal Medicine, private practice. Group setting. Modern office adjacent to 75-bed hospital, Jacksonville, Florida area. Pleasant surroundings, congenial colleagues. Write C-623, Box 2411, Jacksonville, Florida 32203.

**GENERAL SURGEON WANTED:** Certified or eligible, to take over practice of general surgery and gynecology, Palm Beach. Office for rent, equipped. Retiring January 1. Write C-612, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST OR G. P. to join busy two doctor practice. Salary first six to 12 months. Fort Lauderdale. Phone: (305) 564-7597.

INTERNIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to \$40,000 to \$60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-619, P. O. Box 2411, Jacksonville, Florida 32203.

OTOLARYNGOLOGIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to \$40,000 to \$60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-620, P. O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board qualified or certified to join four established internists—general internal medicine. Salary first year, percentage and partnership to follow. Write Pompano Medical Group, P.A., 2480 N.E. 23rd Street, Pompano Beach, Florida 33062. Phone (205) 942-0100.

## Miscellaneous

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccosukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

ER PHYSICIANS: Florida licensed ER physicians needed to join well established group providing ER coverage for 400-bed general hospital located on Florida west coast. Excellent fringe benefits including one month vacation per year and paid Blue Cross/Blue Shield benefits. Ideal working conditions in an area famous for its climate and recreational opportunities. Please send curriculum vitae, C-624, P. O. Box 2411, Jacksonville, Florida 32203.

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EMERGENCY ROOM PHYSICIAN, \$40,000 a year guaranteed minimum pay for four day week with one month vacation. All corp. benefits. Flexible hours, no weekends. New private hospital. American medical school and citizenship required. Call: Thomas Carlson, M.D., Lake Community Hospital, Leesburg, Florida 32748. Phone: (904) 787-6881.

INTERNIST, FAMILY PRACTITIONERS: Central Florida area, Orange County. Area combines best of rural living with easy access to metropolitan area 11 miles away. Privileges available in expanding hospital. Contact Robert Barber, Administrator, West Orange Memorial Hospital, 555 North Dillard Street, Winter Garden, Florida 32787. Phone (305) 656-1244.

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OTOLARYNGOLOGIST, ANESTHESIOLOGIST, E. R. PHYSICIAN AND GENERAL PRACTITIONER. Guarantee, loan and free rent in new professional building available. Contact Claude Weeks, Administrator, Flagler Hospital, P. O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

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EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY: to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of \$40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital.

## situations wanted

UROLOGIST: Completing University training July '74. Age 30, married, board eligible, Florida license. National boards, desires association leading to partnership or group practice anywhere in Florida. Fred P. Sherman, M.D., 20 Lakeview Avenue, Apt. C, Leonia, N.J. 07605. Phone (201) 461-2538.

PH.D. CLINICAL CHEMIST, 6 years clinical laboratory director, Florida clinical lab director's license; Medicare approved; desires position in hospital/clinic/lab/doctor's office. Part time or full time. Write C-615, P.O. Box 2411, Jacksonville, Florida 32203.



**LOCUM TENENS WANTED:** 46 year old board certified pathologist, AP-CP, Florida license, interested in relieving pathologist for several weeks, anytime after October 1, 1973. Contact: C. W. Koehl Jr., M.D., Elmcrest Drive, Dallas, Pennsylvania 18612.

**PSYCHIATRIST,** Age 30, married, excellent training, board eligible. Military obligation completed in July 1974. Experienced in individual and group psychotherapy, family and community consultation. Looking for a professional association, primarily in private practice. Curriculum vitae available on request. Write C-617, P.O. Box 2411, Jacksonville, Florida 32203.

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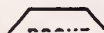
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